Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

Illinois

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The Illinois Department of Healthcare and Family Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., May 10, 2012. You may submit comments on this proposal to IL-MedicareMedicaidCoordination@cms.hhs.gov.

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

PROPOSAL TO THE
CENTERS FOR MEDICARE AND MEDICAID SERVICES:

MEDICARE-MEDICAID ALIGNMENT INITIATIVE

APRIL 6, 2012

Table of Contents

I. EXECUTIVE SUMMARY 1

II. OVERVIEW: MEDICARE-MEDICAID ALIGNMENT INITIATIVE 3

a. Overall Vision/Goal 6

b. Population 7

c. Geography 8

III. CARE MODEL OVERVIEW 9

a. Proposed Delivery System 9

b. Proposed Benefit Design 13

c. Evidence-based Practices 19

d. Context within Current State Initiatives 19

i. Innovations Project 19

ii. Integrated Care Program (ICP) 20

iii. Health Homes 20

iv. Home and Community-Based Services Waivers 20

v. Colbert Consent Decree 20

IV. STAKEHOLDER ENGAGEMENT AND BENEFICIARY PROTECTIONS 21

a. Engagement of Stakeholders During Planning Process 21

b. Ongoing Stakeholder Engagement 22

c. Description of Beneficiary Protections 23

V. FINANCING AND PAYMENT 25

a. Financial Alignment Model 25

b. Incentive Payment Plan 26

c. Quality Measures 26

d. Payments to Providers 26

VI. EXPECTED OUTCOMES 27

a. State ability to monitor, collect and track data on quality and cost outcome metrics 27

b. Expected impact on Medicare and Medicaid costs 28

VII. INFRASTRUCTURE AND IMPLEMENTATION 29

a. State Infrastructure/Capacity 29

b. Expected Use of Contractors 29

c. Overall Implementation Strategy and Anticipated Timeline: 30
VIII. FEASIBILITY AND SUSTAINABILITY 31
a. Potential barriers/challenges and/or future State actions 31
b. Statutory and/or regulatory changes needed 31
c. New State funding commitments or contracting processes necessary 31
d. Scalability and replicability of the proposed model 31
IX. ADDITIONAL DOCUMENTATION 32
a. List of State Plan Amendments 32
X. ATTACHMENTS 33
a. Attachment A: Quality and Pay-for-Performance Measures 33
b. Attachment B: Medicaid Covered Services: 37
c. Attachment C: Home and Community Based Services 38

I. EXECUTIVE SUMMARY

This proposal – to integrate care for individuals eligible for both Medicare and Medicaid under one managed care program – is one in a series of initiatives undertaken by the State of Illinois (State) through its Innovations Project.

The State's Innovations Project is an effort to redesign the health care delivery system to one that is more person-centered with a focus on improved health outcomes, enhanced beneficiary access, and beneficiary safety and to implement Illinois Public Act 96-1501[1]. Due to the fragmented care dual eligible beneficiaries often receive – Medicare and Medicaid often work at cross purposes and impede care coordination – and the high cost of providing care to this population, the State is focusing efforts on improving care for dual eligible beneficiaries while reducing cost growth through its Innovations Project.

On a national level, dual eligible beneficiaries make up 25 percent and 46 percent of Medicare and Medicaid spending respectively.[2] In contrast, dual eligible beneficiaries constitute only 16 percent and 18 percent of Medicare and Medicaid enrollment respectively.[3] In 2005, combined national average per capita spending totaled $26,185.[4] In Illinois, as of December 31, 2010, full dual eligible beneficiaries[5] made up approximately 9 percent of Medicaid full benefit enrollment and 27 percent of Medicaid calendar year 2010 net claims-based costs.

The goals of the Illinois Medicare-Medicaid Alignment Initiative (demonstration) – through integrated Medicare and Medicaid benefits and services, and integrated financing streams – are to:

- Create a unified delivery system that is easier for beneficiaries to navigate;
- Improve care delivery, coordination, and utilization of community-based services;
- Eliminate conflicting incentives between Medicare and Medicaid that encourage cost shifting, reduce beneficiary access to high-quality care and community-based services, and result in a lack of care management for chronic conditions; and
- Achieve cost savings.

To achieve its goals, the State and the Centers for Medicare and Medicaid Services (CMS) will enter into three-year contracts with managed care organizations[6] (Plans) – in select regions of the State – that will be accountable for the care delivered to dual eligible beneficiaries and for robust care coordination

[1] IL Public Act 96-1501 requires at least 50 percent of recipients eligible for comprehensive medical benefits in all programs administered by the Department of Health Care and Family Services (HFS) to be enrolled in a risk-based care coordination program by January 1, 2015.
[2] Medpac Report to the Congress: Aligning Incentives in Medicare. Chapter 5: Coordinating the care of dual eligible beneficiaries. June 2010, page 131.
[3] Ibid.
[4] Medpac Report to the Congress: Aligning Incentives in Medicare. Chapter 5: Coordinating the care of dual eligible beneficiaries. June 2010, page 135.
[5] Individuals receiving full Medicare (Parts A and B) and full Medicaid benefits.
[6] Managed Care Organization refers to a health maintenance organization (HMO) or a managed care community network (MCCN). A MCCN (305 ILCS 5/5-11(b)) is an entity, other than a health maintenance organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with HFS exclusively to persons participating in programs administered by HFS.

efforts where performance will be measured and payment will be tied to quality measurement goals. For individuals receiving full Medicare and full Medicaid benefits, the demonstration will ensure access to all Medicare and Medicaid benefits and comprehensive services that address the Enrollees' full range of needs. Plans must provide or arrange to provide the full array of benefits and supportive services (including pharmacy) afforded individuals under both Medicare and Medicaid. The State is proposing to exclude individuals receiving developmental disability institutional and home and community-based (HCBS) waiver services from participation in the demonstration.

Care will be delivered in a team-based setting with integrated care coordination and care management services based on the needs and goals of Enrollees. Beneficiaries enrolled in the demonstration will choose a medical home that will deliver evidence-based primary care as part of a multi-disciplinary care team. There will be a contractual requirement for Plans to integrate primary and behavioral health services and an emphasis on coordinating care across providers.

The State will ensure sufficient beneficiary protections including choice to participate in the demonstration, choice of providers within the network, opportunities to maintain relationships with existing providers, and the ability to change or opt out of Plans at any time. In addition, Plans will be required to implement meaningful consumer input processes in their ongoing operations and measure quality of service and care. The State will hold stakeholder meetings throughout the operation of the demonstration to ensure beneficiary satisfaction and quality of care.

To ensure beneficiary protection, participation in the demonstration will be voluntary. The State and CMS will implement a passive enrollment process where beneficiaries will have the opportunity to make an affirmative choice of whether or not to enroll. Beneficiaries that do not make an affirmative choice will be auto-assigned to a Plan with the ability to opt-out or affirmatively select another Plan at anytime. Enrollment will be supported by clear and accessible information – and facilitated by a neutral enrollment broker – so that beneficiaries have all the necessary information to make an informed choice to enroll.

The proposal uses the State's experiences implementing the Integrated Care Program (ICP) to develop a managed care program that will improve the quality of care delivered to dual eligible beneficiaries. Implemented in 2011, the ICP is a managed care program for Seniors and Adults with Disabilities (excluding dual eligible beneficiaries) in the Illinois counties of Suburban Cook, DuPage, Lake, Kankakee, Will and Kane, where local primary care physicians, specialists, hospitals, nursing homes, and other providers collaborate as a team to organize care around the needs of the beneficiary in order to achieve improvements in health. Highlights include:

- Better coordination of care, as members work with a team of providers to give them the best possible healthcare;
- Opportunity for beneficiary involvement in all healthcare decisions; and
- Additional programs and services to help beneficiaries live a more independent and healthy life.

The proposal outlines the State's approach to developing and implementing a Medicare-Medicaid alignment model that will improve care for dual eligible beneficiaries, help the State achieve its goal to implement Public Act 96-1501 by January 1, 2015, and align with Affordable Care Act (ACA) initiatives. The State looks forward to working with the Centers for Medicare and Medicaid Services (CMS) toward approval of the Illinois Medicare-Medicaid Alignment Initiative.

II. OVERVIEW: MEDICARE-MEDICAID ALIGNMENT INITIATIVE

The State is anticipating implementing a program similar to the ICP for dual eligible beneficiaries that focuses on improved coordination of care. The demonstration will utilize managed care organizations (Plans) to provide all covered services. This program will combine Medicare and Medicaid funding under a blended capitation payment to provide integrated, comprehensive care to full-benefit dual eligible beneficiaries ages 21 and over. The chosen Plans will be responsible for providing all medical, behavioral health, pharmacy, and long-term services and supports (LTSS) for Enrollees.

Plans must have networks that include providers that act as medical homes and coordinate high-quality, person-centered, planned care and are supported by care teams and the use of health information technology. The program will include unified requirements and administrative processes that – to the extent possible – accommodate both Medicare and Medicaid including network adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes. The program will also include beneficiary protections such as:

- An ability to opt-out of the program at any time;
- On-going stakeholder input process at both the State and Plan levels;
- Choice of at least two Plans in a contracting area;
- Choice of providers within Plan network; and
- Emphasis on continuity of care as beneficiaries are transitioned into the program.

The chart below provides a high-level overview of the proposal.

Overview of the Illinois Medicare-Medicaid Alignment Initiative

Target Population	Full benefit Medicare-Medicaid beneficiaries ages 21 and over in the Aged, Blind, and Disabled (AABD) category of assistance in the counties specified below. The target population excludes individuals receiving developmental disability institutional and HCBS waiver services, the spend-down population, individuals enrolled in partial benefit programs, and those with high third party liability.
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	250,600
Total Number of Beneficiaries Eligible for Demonstration	156,000

Geographic Service Area	In year one, Plans[7] will propose to serve one or both of the following service areas: Greater Chicago: Cook, Lake, Kane, DuPage, Will, Kankakee counties Central Illinois: Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, Stark counties For operation during year two of the demonstration, the State plans to expand the service areas operating under the demonstration and to release a second Request for Proposals (RFP) for Plans to serve the following geographic areas: Rockford: Winnebago, Boone, and McHenry counties East St. Louis: Madison, Clinton, and St. Clair counties Quad Cities: Rock Island, Mercer, and Henry counties
Summary of Covered Benefits	All Medicare (Parts A, B, and D) and Medicaid covered services including long-term care institutional and community-based services and supports.
Financing Model	Fully Capitated Contracts

[7] MCCNs may propose to serve a limited geographic area on a county-by-county basis.

Summary of Stakeholder Engagement/Input	Ongoing Efforts: Throughout the operation of the demonstration, Plans will be required to have quarterly consumer advisory board meetings. The State will maintain its website to provide updates on the demonstration (http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx) and have ongoing, quarterly stakeholder meetings through the Medicaid Advisory Committee (MAC), the MAC Care Coordination Subcommittee, and the Seniors and Persons with Disabilities (SPD) stakeholder group. These meetings will be available in alternative formats for individuals with disabilities. The next SPD stakeholder meeting to discuss this demonstration is scheduled for April 11, 2012 at 1 PM. Please refer to the State's website for location and dial-in information. In addition, the State will contract with an outside entity to conduct an independent evaluation (with consumer participation) of the demonstration to ensure Plans are meeting the needs of Enrollees and to promote continuous quality improvement. The State will maintain an email box for comments or concerns regarding the operation of the demonstration. Please use the subject line "Dual Capitation Initiative" and the following email address: HFS.carecoord@illinois.gov. Summary of Efforts To-date: SPD stakeholder meeting – March 14, 2012; SPD stakeholder meeting – March 7, 2012; SPD stakeholder meeting – February 23, 2012; MAC Meeting – 1/19/12; MAC Care Coordination Subcommittee – 1/10/12; MAC Long-term Care Subcommittee – 12/16/11; MAC – 11/18/11; MAC Care Coordination Subcommittee Meeting – 11/15/11; Kickoff Meeting Questions and Answers posted – 11/30/11; Innovations Project Kickoff Meeting – 10/13/11; Coordinated Care Key Policy Issues June 2011; and 13 SPD stakeholder meetings between April 2010 and December 2012.
Proposed Implementation Date	January 1, 2013

a. Overall Vision/Goal

The State envisions a program that overcomes barriers to integration and improves upon and coordinates care for dual eligible beneficiaries who often have complex care needs and whose care is typically uncoordinated between Medicare and Medicaid or within either program. The following describes how the State's model overcomes the typical barriers to integration of Medicare and Medicaid to ultimately improve the care provided to dual eligible beneficiaries:

- Unified Administrative Processes: Currently, dual eligible beneficiaries have to navigate two programs with different yet overlapping benefits, differing eligibility and coverage rules, and separate sets of administrative processes and information notices to beneficiaries. Under the State's proposed model, the State and CMS will work to create unified administrative processes for beneficiaries including a seamless enrollment and disenrollment process for both programs and a single appeals process. Plans will provide a single Enrollee handbook that educates Enrollees on how to access Medicare and Medicaid services. At the same time, combined and unified administrative processes aim to reduce costs, as both programs currently have to operate separate administrative processes for activities such as enrollment.

- Improved Care Coordination: Dual eligible beneficiaries often have multiple chronic conditions and/or disabilities that result in high program spending, but whose care is often uncoordinated across the two programs that provide necessary services. Lack of coordination across the two programs may often lead to unmet needs, underutilization of community-based services, and lack of care management for chronic conditions.

  The State's proposal will improve upon the care delivered to dual eligible beneficiaries – who often have considerably varied care coordination needs – by establishing medical homes and person-centered care coordination requirements so that providers are aware of individuals acute and chronic medical, behavioral health, long-term care, and social service needs and the care they receive. The State will ensure a seamless experience for beneficiaries transitioning into the program. The State's proposal will also increase access to appropriate and cost-effective services with improved utilization of community-based services, when appropriate, and integration of physical and behavioral health services. The demonstration will implement team-based care coordination and care planning that is based on individual need and directed by each Enrollee's needs, goals, and preferences.

- Integration of Financing: The current misalignment of funding (separate payment and data collection for Medicare and Medicaid) and reliance on an inefficient fee-for-service (FFS) system further complicates the fragmented relationship between the two programs and exacerbates the effects of lack of care coordination. This financial misalignment may lead to the Medicare and Medicaid programs working in opposition and provides incentives to avoid costs rather than coordinate care. It can also lead to reliance on less appropriate and more costly hospital-based care and institutional LTSS. For example, in the past, States have not been able to share in savings to Medicare for increased Medicaid costs associated with transitioning more dual eligible beneficiaries to community-based care (typically a Medicaid covered service). In addition, States have historically not had access to Medicare data to fully understand dual eligible beneficiary utilization patterns in order to implement robust care coordination programs. Integrated financing attempts to overcome these barriers and encourage coordinated care across the two programs.

Under the State's proposal, Plans will receive a single capitation payment for all covered benefits and services to eliminate cost shifting incentives between the two programs. In addition, Plans receiving full payment will be linked to meeting annual quality measure targets as an incentive to study beneficiary utilization patterns and to implement the robust care coordination requirements proposed by the State.

b. Population

Within the selected geographic areas, the population that is eligible for the demonstration is full-benefit dual eligible beneficiaries – those that receive full Medicare (Parts A and B) and full Medicaid benefits – up to 100 percent of the federal poverty level and ages 21 and over. The demonstration population includes individuals in the AABD category of assistance only. The demonstration population excludes individuals receiving developmental disability institutional and HCBS waiver services, the spend-down population, individuals enrolled in partial benefit programs, and those with high third party liability.

As of December 31, 2010, there were approximately 137,000 beneficiaries in the demonstration population targeted for enrollment in year one: approximately 119,000 in the Greater Chicago service area and 18,000 in the Central Illinois service area (78.5% of the Greater Chicago region individuals reside in Cook county). As of December 31, 2010, there were approximately 19,000 beneficiaries in the demonstration population targeted for enrollment in year two: 7,100 beneficiaries in the Rockford service area, 9,200 beneficiaries in the East St. Louis service area, and 2,900 beneficiaries in the Quad Cities service area.

55.7 percent of the demonstration population is age 65 or older. For the demonstration population, the average Medicaid per member per month calendar year (CY) 2010 net costs were $797 compared to $323 for all other full benefit Medicaid beneficiaries in Illinois. There was very little difference in costs between the regions targeted for enrollment in years one and two.

Of the demonstration population, 19 percent received care in an institutional setting and 17 percent received care in a HCBS setting and contributed approximately 34 percent and 24 percent of total institutional care costs and HCBS costs among all full benefit Medicaid beneficiaries Statewide. Individuals with serious mental illness[8] (SMI) constitute 21 percent of the demonstration population and approximately 38 percent of this subpopulation received care in an institutional setting. The chart below provides more detail on the demonstration population as of December 31, 2010.

[8] Serious Mental Illness (SMI): For purposes of these statistics, the State used the following diagnoses schizophrenia (295.xx), schizophreniform disorder (295.4), schizo-affective disorder (295.7), delusional disorder (297.1), shared psychotic disorder (297.3), brief psychotic disorder (298.8), psychotic disorder (298.9), bipolar disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, cyclothymic disorder (301.13), major depression (296.2x, 296.3x), obsessive compulsive disorder (300.30), anorexia nervosa (307.1), and bulimia nervosa (307.51).

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Overall total	156,162	29,703	26,807
Age 65+	87,020	22,100	19,814
Under Age 65	69,142	7,603	6,993
Individuals with serious mental illness	33,443	12,741	3,132
Age 65+	10,436	6,864	1,770
Under Age 65	23,007	5,877	1,362

Among dual eligible beneficiaries, care coordination needs vary greatly depending upon considerations such as age, health status, whether an individual has a physical or intellectual disability, the incidence and variety of chronic conditions, and whether the individual receives care in an institutional or community setting. As such, the State proposes to implement a demonstration that is sensitive to individual health needs and goals in order to promote person-centered care coordination and planning.

c. Geography

In year one of the demonstration, the State proposes to operate the demonstration in two service areas. The Greater Chicago service area will include the following counties: Cook, Lake, Kane, DuPage, Will, and Kankakee. The Central Illinois service area includes the following counties: Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, and Stark. Plans may choose to serve one or both of the defined service areas. Plans must offer to serve the entire defined service area(s) it chooses. An MCCN may propose to limit its scope within each geographic service area on a county-by-county basis.

In order to select Plans to operate in the defined service areas, the State will issue a competitive Request for Proposals (RFP). The State will seek proposals from Plans that provide comprehensive and creative approaches to managing the care of dual eligible beneficiaries and implement and provide assurances that the Plan can manage the demonstration requirements. In order to maintain beneficiary choice, in year one, the State plans to award contracts to up to five Plans in the Greater Chicago service area and at least two Plans in the Central Illinois service area. Beneficiaries will always have a choice of at least two Plans serving the entire geographic service area in addition to any selected MCCN serving a limited geographic area. The State will limit the number of Plans in each service area in order to ensure sufficient lives to make Plans viable and capable of making the investments necessary for the type of care coordination desired.

In year two of the demonstration, the State proposes to issue a second competitive RFP to expand operation of the demonstration to three additional service areas. The Rockford service area will include Winnebago, Boone, and McHenry counties. The East St. Louis service area will include Madison, Clinton,

and St. Clair counties. The Quad Cities service area will include Rock Island, Mercer, and Henry counties. In year two, beneficiaries will also always have a choice of at least two Plans serving the entire geographic service area in addition to any MCCN serving a limited geographic area.

The State selected the regions for enrollment in years one and two of the demonstration because of the density of the dual eligible population and the existence of a robust medical infrastructure and choice of providers. The State feels that these factors will contribute to the success of this demonstration and allow at least two competing Plans to be viable.

III. CARE MODEL OVERVIEW

a. Proposed Delivery System

Through the implementation of the demonstration, the State expects to improve the quality of care delivered to dual eligible beneficiaries through improved coordination of Medicare and Medicaid covered services and implementation of a medical home and care planning requirements that support individual beneficiary needs. The State plans to solicit proposals and to contract with Plans that will be responsible for the delivery of all covered Medicare and Medicaid benefits and services, and for the provision of extensive care coordination activities. The State will jointly oversee the implementation and operation of the demonstration with CMS.

Under the proposed demonstration, care delivery will be anchored in a medical home and supported by care teams that are tailored and personalized to meet individual care needs and focused on providing a multidisciplinary approach to care delivery, care coordination, and care management for those with complex needs. Plans will be required to assure the integration of physical and behavioral health services. In addition, Plans will be required to develop and maintain networks that assure access to all necessary services and to maintain relationships with community-based organizations to focus on and ensure independence for seniors and individuals with disabilities. See Section b: *Proposed Benefit Design* for more detail.

All applicable Medicare and Medicaid statutory and regulatory requirements will apply to the demonstration unless explicitly waived through the Memorandum of Understanding to be negotiated between the State and CMS.

- Enrollment: Participation in the demonstration is voluntary. Enrollees will have the choice of whether or not to participate in the demonstration. The State will implement a unified, passive enrollment process that provides beneficiaries the opportunity to enroll or disenroll from a Plan at any time. Beneficiaries will have the opportunity to choose from at least two Plans (and more in the Greater Chicago service area) serving the entire geographic area in addition to any selected MCCN serving a limited geographic area, or to choose to remain in Medicaid FFS. Enrollees will not be locked-in to Plans and will be able to disenroll or transfer Plans on a month-to-month basis at any time during the year. Additionally, Enrollees will not be locked-in to primary care physicians (PCPs). Requests to change PCPs will occur within 30 days. The State will work with CMS to develop a single unified enrollment process.

- Passive Enrollment: Beneficiaries will receive notices that they have been auto-assigned to a Plan. Beneficiaries will then have the opportunity to make an affirmative choice (within a specified time period) to remain with the Plan where they have been auto-assigned, to choose another Plan, or to remain in Medicaid FFS. If a beneficiary does not exercise an affirmative choice, they will be enrolled in the Plan where they have been auto-assigned. The State will work with CMS to ensure beneficiaries have ample time and opportunity to make an informed choice. Enrollees will not be locked-in to Plans and will be able to disenroll or transfer Plans on a month-to-month basis at any time during the year.

  The State will work to ensure that beneficiaries remain with their current providers and/or Plans when possible. The State plans to work with CMS to ensure that future auto-assignment will be set so that higher performing Plans (according to variables such as quality measurement and consumer satisfaction) are preferred and lesser performing plans will be at risk of suspension of new enrollment.

- Enrollment Phase-in: The State is proposing to phase-in enrollment to ensure Plans have adequate time to process enrollment, complete health risk assessments, and to ensure a smooth transition for Enrollees. Consistent with CMS guidance, the State will first phase-in individuals who affirmatively chose to enroll in the demonstration and individuals eligible for the low-income subsidy who would otherwise be subject to the annual Prescription Drug Plan (PDP) reassignment. Those individuals who are phased-in first will have enrollment effective dates of January 1, 2013. The State proposes to phase-in a maximum of 5,000 Enrollees per Plan per month thereafter. The State will not auto-assign a number of beneficiaries to a MCCN that exceeds its capacity. Enrollees will receive auto-assignment notices with ample time to make an informed choice. The enrollment notice will include the effective date of enrollment into a Plan, which will coincide with the first of every month.

- Client Enrollment Broker (CEB): A CEB – under contract with the State – will facilitate enrollment. In order to support enrollment decisions, the State will ensure that beneficiaries are educated on Plan benefits and networks, the processes for opting out of the demonstration or changing PCPs, and the unified grievance and appeals processes. The State will focus on developing clear and accessible information (ensuring availability in alternative formats and languages) on available Plans and beneficiary protections (including whether members' doctors and providers are in Plan networks and the benefits available through Plans). The State understands that beneficiaries may be hesitant to embrace managed care and will work with stakeholders to alleviate concerns and ensure that they have enough information to make an informed choice about enrollment. In order to help facilitate enrollment choices, the State will contract with a neutral enrollment broker to help deliver Plan information and to conduct outreach for potential Enrollees. To ensure that enrollment information is available and accessible to all potential Enrollees, the State will ensure that auxiliary aids and services are available, upon request.

  In order to ensure that enrollment notices are understandable to the reader, the State intends to use the MAC Client Education Subcommittee to review and comment on enrollment notices before they are sent to beneficiaries.

- Plan Requirements: Plans will be limited to a number of Enrollees that does not exceed their capacity to provide the full continuum of Medicare and Medicaid benefits covered under the

demonstration. Plans must be licensed according to State licensure and solvency requirements. Furthermore, Plans providing services under the demonstration must be National Committee for Quality Assurance (NCQA) accredited within three years of the demonstration effective date.

- Provider Networks: Plans will be required to establish and maintain a network of providers – either directly or through sub-contractual arrangements – that assures access to all Medicaid and Medicare benefits and services. The networks must include a broad array of providers including PCPs, specialists, behavioral health providers, ancillary providers, hospitals, pharmacists, home health agencies, advanced practice nurses (APNs), and providers of LTSS and other community supports. The State will thoroughly evaluate Plan networks to assure adequate access including variety of available providers, after hours availability, geographic location of providers, distance, travel times, and physical accessibility for those with disabilities.

  In addition, Plans will be required to co-locate physical and behavioral health. Co-location of physical and behavioral health may be accomplished through co-location of practices, the placement of a behavioral health clinician in a primary care setting, the placement of a primary care clinician in a behavioral health practice, or an alternative arrangement. The State, in conjunction with CMS, will negotiate with Plans the approach to co-location, which will become a contractual requirement.

  Plans must credential providers in accordance with NCQA standards, when applicable, and State standards, otherwise, and must recredential every three years. In addition, providers must be Medicare and Medicaid-certified and eligible to receive payment under both programs.

  - Network Adequacy / Access to Care: Learning from our experience in the ICP, the State plans to ensure network adequacy before implementation. The State expects that Plans will be able to build adequate networks more quickly under the demonstration because Medicaid providers are acknowledging the movement to managed care in Illinois and some potential Plans will have experience and established networks with Medicare. In addition, Plans will be required to conduct outreach to beneficiaries' current providers and propose mechanisms to: encourage beneficiaries' current providers to enroll in its network to ensure continuity of care; ensure providers in its network will accept new beneficiaries; and ensure network providers are multi-lingual and culturally relevant for the community it proposes to serve.

    Plans must have a network that consists of providers, particularly specialists, with experience serving various disability types and relationships with community organizations that focus on recovery and independence for those with mental illness. In order to ensure Plans are able to build adequate networks, the State will provide to interested Plans files containing information on Medicaid providers currently providing services to dual eligible beneficiaries in the demonstration areas.

    Plans will be required to establish and maintain provider networks that at least meet State Medicaid access standards for long-term care services and Medicare access standards for medical services and prescription drugs. The State and CMS will negotiate network adequacy requirements for areas of overlap between the two programs, such as home health care services. Additional requirements will be imposed, including:

    - Plans will be limited to a maximum PCP to Enrollee ratio of 1:600;

- Specialists may act as PCPs;
- Plans will be required to analyze network adequacy on a weekly basis in the first three months after implementation, monthly in the next three months, and quarterly thereafter. Plans will be required to immediately identify gaps and develop recruitment strategies as necessary. Plans will be required to have contingency plans in case of network inadequacy, a provider contract termination, or insolvency;
- PCPs and specialty providers must have published after-hours telephone numbers to ensure access to care; and
- Plans will work with providers to comply with the American Disabilities Act (ADA) and to demonstrate the capacity to deliver services in a manner that accommodates special needs. Plans will be required to submit ADA compliance plans and describe how they will ensure access to services equivalent to those offered at inaccessible facilities.

- Outreach and Marketing: The State, in conjunction with CMS, will develop unified marketing and outreach rules that include both Medicaid and Medicare requirements as appropriate. All Plan marketing materials will require CMS and State prior approval. To ensure effective communication, written documents must be at a sixth grade reading level and Plans must offer translated materials and alternative methods of communication such as audio recordings. The State will contract with a neutral enrollment broker to increase awareness about the demonstration and to inform enrollment choices through avenues such as mailings or print and virtual media and through outreach and education sessions for Potential Enrollees.

- Grievances and Appeals Process: The State, in conjunction with CMS, will develop a unified grievance and appeals process. The appeals process will include an exhaustion of the Plan's internal appeals process prior to review by the Medicare-qualified external independent contractor.

    - Internal appeals processes will be governed by a unified set of requirements for Plans that incorporate relevant Medicare Advantage, Part D, and Medicaid managed care requirements; and
    - The State, with CMS, will develop one document describing this unified process.

- Quality Measurement: At a minimum, the State will use quality measures from the ICP to assess Plan performance. See *Attachment A: Quality and Pay-for-Performance Measures* for an initial list of proposed measures. The State will work with CMS to identify additional measures and finalize the measures to be used as pay-for-performance. See *Section V: Financing and Payment* for more details on pay-for-performance. The State intends to make Plan quality measure results publicly available on the web and in alternative formats upon request.

  The State will work with CMS, Illinois stakeholders, and the University of Illinois at Chicago (UIC) to explore personal outcome measures, improved LTSS quality measures, and additional measures of community integration and beneficiary empowerment. The State received, through the public comment period, a recommendation to consider the Council On Quality and Leadership's *Personal Outcome Measures*. The State intends to partner with the UIC for an independent evaluation of the demonstration and will ask UIC to consider this tool in development of methods to measure personal outcomes.

- Quality Reporting and Performance Improvement: The State will develop a single, comprehensive quality management and consolidated reporting process. The State along with CMS will require the development of an ongoing quality improvement program including performance improvement projects.

b. Proposed Benefit Design

Plans must have the capacity to provide or arrange to provide all demonstration covered services and operate a care coordination model that is anchored in a medical home, tailored to individual need, takes into account whether an individual has a physical or intellectual disability, and is supported by multidisciplinary care teams. Plans will be required to implement care models that are built on Enrollee's needs and preferences and delivered in a culturally and linguistically appropriate environment.

- Covered Services: The demonstration will make selected Plans responsible for providing or arranging to provide all Medicare services in accordance with 42 C.F.R. 422.101 (including inpatient, outpatient, hospice, home health, and pharmacy) and all Medicaid services including behavioral health, long-term institutional and community based LTSS. (See *Attachment B: Medicaid Covered Services* for a list of Medicaid State Plan services and *Attachment C: Home and Community Based Services* for the HCBS waiver services). Medicare Part D requirements will apply to Plans including, but not limited to, benefits, cost sharing, network adequacy, and formularies.

  Plans may propose to offer supplemental benefits that exceed those currently provided in either Medicare or Medicaid as long as they are provided under the blended Medicare and Medicaid capitation rate. Plans will be responsible for coordinating referrals for other non-covered services, such as supportive housing and other social services to maximize opportunities for independence in the community.

  Plans will employ utilization management tools, including any prior approval requirements for all services provided by the Plan and its provider network, and will have procedures for determining a medically necessary service, according to a plan approved by the State and CMS.

- Cost sharing: Currently, dual eligible beneficiaries in Illinois are subject to minimal cost sharing for Medicaid services. Plans may not charge cost sharing to beneficiaries above levels established under the State Medicaid plan, but Plans are free to waive Medicaid cost sharing requirements.

- Medical Homes: Plans must operate networks – from which Enrollees will choose a medical home – that include providers that act as medical homes with a focus on Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), PCP-centered medical groups, and private practice PCP offices. Medical homes will provide evidence-based primary care services, acute illness care, chronic health condition management, and referrals for specialty care. Medical homes will be supported by health information technology (HIT) and be a part of the multidisciplinary care team to assist in coordinating care across the full spectrum of available services, managing transitions between levels of care, and coordinating between physical and behavioral health. The State recognizes that not all primary care offices are ready or capable of operating as true medical homes. However, the Plans will be required to have a process in place to facilitate medical homes advancing

towards NCQA certification, and will be required to provide financial incentives to providers that achieve NCQA medical home certification.

- Care Coordination: Plans will be required to provide care coordination services that ensure effective linkages and coordination between the medical home and other providers and services, monitor transitions between levels of care, facilitate discharge planning, and provide care management for those identified to have complex needs. Plans will be required to assure access to HCBS waiver services when appropriate and coordination with non-covered community-based resources through coordination and/or contracting with existing community-based organizations and providers. Current eligibility determination guidelines for HCBS services will not change under the demonstration unless modified by the State. During transition, Plans will be required to coordinate with HCBS case managers to understand Enrollee needs and care plans.

  Effective care coordination will include the following components:

  - Health Information Technology: The State will seek Plans that have technology in place to assist with care coordination that includes a clinical information system to be used to track care delivered outside the medical home. The State will seek Plans that have care coordination software that supports care management activities such as storing Enrollee assessments, claims data, authorizations, and treatment plans; generating follow up tasks for care coordinators; customizing goals to meet specialized needs of Enrollees; and establishing benchmarks to evaluate progress and health outcomes for Enrollees receiving care management services.

    The State will seek Plans that will operate a secure web-based application for Enrollees and providers. The State desires that the web-based Enrollee portal provide information about the Plans and include Enrollee health history and care plans. The web-based secure application for providers should include care plans, claims information, demographics, and lab results and provide the option for entry by providers at the point of service. Plans must build and support various interfaces between Plans and providers to routinely share key information as appropriate for the technological capacity of individual providers. The information technology will be used by medical homes, the multidisciplinary care team, and other providers to monitor:

    - Provider/Enrollee communication;
    - Enrollee profiles including demographics, claims payment information, goals, care plan adherence, care gap alerts, lab results, etc.; and
    - Inbound and outbound Enrollee contact.

    Plans shall ensure the privacy of Enrollee health records and provide for access to such records by Enrollees. The State will adhere to and ensure Plans comply with privacy laws. The State recognizes that the technology described above will not be available system-wide at implementation. Selected Plans will have laid out a timeline and strategy for rolling out the capabilities described.

  - Care Management Identification: Plans will be required to identify Enrollees as needing care management through the use of the following:

- Health Risk Questionnaire: Plans will administer a health risk questionnaire (HRQ) to all new Enrollees within 90 days after enrollment. The HRQ will collect information about the Enrollee's physical, psychological, and social health. The Plans will use the information to guide the administration of a more in-depth health risk assessment and, if needed, a behavioral health risk assessment. Assessments must be completed within 120 days after a completed HRQ indicates the need for further assessment.

- Predictive Modeling: Plans will also use claims data provided by the CMS and the State to help identify Enrollees in need of care management.

- Surveillance Data: Plans will also use referrals, transition information, service authorizations, families, caregivers, and providers to help identify Enrollees in need of care management.

o Risk Stratification: Once identified for care management, Plans will stratify Enrollees to determine the appropriate level of intervention. Enrollees are generally stratified into three levels: low, moderate and high risk. Those stratified as moderate or high risk are given an in depth health assessment, and if needed, a behavioral health risk assessment. There is outreach and intervention at each care management level. Those Enrollees, stratified to high-risk or moderate-risk, are assigned a care team who will develop a care plan with the help of the Enrollee and provide care management services. Enrollees who are identified as low risk receive prevention and wellness program services and education on condition-specific issues.

o Continual Risk Assessment: Plans will analyze predictive modeling reports and other surveillance data of all Enrollees monthly to identify risk level changes. As risk levels change, assessments will be completed as necessary and care plans and interventions updated. Plans will reassess members at high-risk at least every 30 days and those with moderate-risk at a minimum of every 90 days, and update the care plan as needed.

o Care Management: For those identified through the health risk and behavioral health screening as needing care management, a multi-disciplinary care team will work with the Enrollee to develop a care plan and provide care management services including wellness programs, discharge planning, medication management, Enrollee health education, assuring integration of specialty care, and referrals for behavioral health and community-based services and resources. The care team will also work to coordinate care across providers and manage transitions between levels of care.

The goals of care management are to ensure the delivery of high quality care; improve health status; enhance coordination across the spectrum of the health care system with particular emphasis on transitions between levels of care; reduce avoidable hospitalizations; and identify opportunities that support recovery and independence in the community.

o Multi-disciplinary Care teams: Multi-disciplinary care teams will support medical homes and provide care management for those identified through the health risk and behavioral health assessments as moderate or high-risk. Teams may include (as appropriate to individual need) an assigned care coordinator, behavioral health professional, the PCP, a community liaison, home health aide, pharmacist, and specialist. The State encourages Plans to use

peer support, recovery specialists, and social workers on the care team as appropriate to the individual. The Enrollee will be provided the opportunity to be an active participant in their care team.

Care coordinators will lead these care teams and will have prescribed caseload limits that vary based on risk-level. Care coordinators will have specific assigned caseloads with whom they develop relationships. The State expects some care coordinators will be site-located at high-volume providers and associated with provider practices otherwise. Plans may use, for example, APNs or social workers to fill these roles. Plans will ensure that care coordinators are culturally competent and have the training to work with and address the diverse needs of the population. Plans must ensure that Enrollees have adequate access to his or her team through methods such as regularly scheduled appointments including face-to-face visits and email and telephone options.

- Care Coordinator Responsibilities include:

    - Conducting health risk and behavioral health assessments;
    - Developing care plans based on Enrollee goals and in conjunction with the Enrollee and care team;
    - Monitoring care plans;
    - Managing and tracking goal attainment, assessments, lab results, and referrals made by the PCP – to ensure timely transmission of information;
    - Identifying, in conjunction with the community liaison, available HCBS services and community-based resources and monitoring use of services;
    - Coordinating with the HCBS case managers for determinations of functional eligibility for the waiver services;
    - Coordinating and maintaining critical information sharing among the care team and Enrollee; and
    - Ensuring that Enrollees are meaningfully informed about their care options.

- Care Team Responsibilities include:

    - Supporting the medical home to coordinate care across the spectrum of the health care system including managing transitions between levels of care;
    - Assisting in early identification, documentation, and communication of changes in health status of beneficiaries;
    - Providing self-management training;
    - Ensuring behavioral health, social, and functional needs are met;
    - Identifying community resources and non-covered services;
    - Providing Enrollee health education; and
    - Assuring integration of the following services across settings and with the medical home:
        - Specialty care;
        - Medication management;
        - Institutional care;
        - Inpatient;
        - Behavioral health;

- Emergency room (ER); and
- LTSS.

- Care Plans: Through the care coordinators and care teams, Plans will be required to work with the beneficiary and his or her family and/or caregiver to develop a single comprehensive person-centered Enrollee care plan for each Enrollee stratified through the health risk or behavioral health screening as moderate or high-risk. The care plan must incorporate strategies and identifiable goals to address the Enrollee's needs and preferences. Plans shall use the Enrollee care plan to facilitate monitoring of an Enrollee's progress toward the Enrollee's goals and evolving service needs.

  Enrollees must be allowed to participate in their own care plan development, including the selection of providers and services to receive or not receive. The Enrollee, their PCP, other providers, a legal representative, family and/or caregiver shall be provided the opportunity to collaborate on the development and implementation of the Enrollee care plan. Each Enrollee will have the opportunity to confirm agreement with the Enrollee care plan.

  - Elements of Care Plan: Based on the needs and preferences as identified through the health risk or behavioral health assessment, the care plans should include:

    - Summary of Enrollee's health history;
    - Enrollee's goals;
    - Actions, including interventions to be implemented;
    - Progress noting Enrollee's success;
    - Barriers or obstacles;
    - Timeframes for completing actions;
    - Status of Enrollee's goals;
    - Crisis plans for an Enrollee with behavioral health conditions;
    - Determinations of need for community resources and non-covered services; and
    - Negotiated risk identification and documentation.

- Hospitalist program: The State recommends that Plans operate a hospitalist program. Hospitalist programs should be designed to minimize admissions and length of stay and to ensure adequate discharge planning. Hospitalist activities shall include Enrollee care, and communication with families and significant others, PCPs, and hospital leadership.

- SNFist program: Plans will be required to have a SNFist program designed to improve health outcomes among nursing home residents particularly those with high-levels of hospitalizations. The SNFist program will include an adequate network of providers – physicians or APNs – that are part of a coordinated group working together and specializing in medical care for the population residing in nursing homes. The SNFist program must include visiting onsite care by the SNFist in the nursing home to provide constant monitoring of Enrollee health status and continual updates to the Enrollee care plan (if applicable).

- Other Requirements: In addition to providing the care coordination services outlined above, Plans will be required to assure beneficiary access to quality care including:

  - Telephone Access: Plans will be required to employ customer service representatives that are culturally competent and sensitive to the population served. Plans will be required to establish a toll-free telephone number, available twenty-four hours, seven days a week, for Enrollees to confirm eligibility for benefits and seek prior approval for treatment where required by the Plan, and shall assure twenty-four hour access, via telephone(s), to medical professionals, either to the Plan directly or to the PCPs, for consultation to obtain medical care.

    Plan will also be required to establish a toll-free number available, at a minimum during working hours on business days. This number will be used: to confirm eligibility for benefits, for approval for non-emergency services, and for Enrollees to call to request PCP changes, to file complaints or grievances, to request disenrollment, to ask questions, or to obtain other administrative information.

  - Nurse Advice Line: Plans shall be required to establish a toll-free nurse advice line, available twenty-four hours a day, seven days a week, through which Enrollees may obtain medical guidance and support from a nurse. Plan shall ensure that the nurses staffing the nurse advice line will be able to obtain physician support and advice.

  - Engagement of Enrollees: Plans will use a multifaceted approach to locate and engage Enrollees and shall capitalize on every Enrollee contact to engage the Enrollee in their own care. For example, Plans will implement a telephonic outreach program to educate and assist Enrollees in accessing services and managing their own care. Calls will be made by Plan staff, or by the nurse advice line, to new Enrollees and to targeted populations such as Enrollees who are identified or enrolled in care management, who have frequent emergency room utilization or who are due or past due for services.

  - Enrollee Health Education: Plans must offer health education programs that use comprehensive outreach and communication methods to effectively educate Enrollees, their families or caregivers about health conditions and self-care and how to access plan benefits and supports. Plans may offer Enrollee incentive programs to promote personal health responsibility and ownership. The incentives offered by the Plan to eligible Enrollees may include rewards for completing annual preventive health visits; attending a follow-up visit within seven days after discharge of an admission for mental illness; and completing other recommended preventive health and chronic health condition screenings.

  - Additional Benefits or ancillary/supportive services: Plans will be asked to propose additional benefits or services – within the blended capitation rate – that will help Enrollees stay in or move to the community.

c. Evidence-based Practices

The State expects Plans to apply well-established evidence-based clinical guidelines promulgated by leading academic and national clinical organizations. Plans will be required to have processes for educating providers on employing evidence-based guidelines and for monitoring providers' use of evidence-based practices. Plans shall adopt clinical guidelines for chronic conditions including asthma; coronary artery disease; diabetes; behavioral health screening, assessment, and treatment including medication management and PCP follow up; and clinical pharmacy medication review.

Plans will be required to utilize evidence-based practice guidelines that are relevant to the demonstration. Examples include the Coleman or Naylor care transition models, Assertive Community Treatment, and Integrated Dual Diagnosis Treatment. The State encourages Plans to use evidence-based guidelines that emphasize early identification, documentation, and communication of the changes in health status of beneficiaries residing in Nursing Facilities or Skilled Nursing Facilities in order to improve care and reduce the frequency of potentially avoidable transfers to acute care hospitals.

In addition, the State expects Plans to operate programs supported by evidence-based clinical guidelines, such as a SNFist program, designed to improve overall health status of Enrollees with an emphasis on reduced hospitalizations. See *Section b: Proposed Benefit Design* for more detail on the SNFist program requirements.

d. Context within Current State Initiatives

i. Innovations Project

This program is one in a series of the State's initiatives to transform the health care environment in Illinois to one that is more person-centered with a focus on improved health outcomes, enhanced beneficiary access, and beneficiary safety. Within the Innovations Project, the State is focusing on providing care coordination delivery options and improving the care provided to those with complex needs including dual eligible beneficiaries. The State recently released a solicitation requesting proposals for Care Coordination Entities (CCE)[9] and MCCNs[10] where, at a minimum, hospitals, physician groups, and behavioral health providers would form a collaboration through a legal entity to coordinate care across the spectrum of the healthcare system for Seniors and Persons with Disabilities (SPD) including those dually eligible for Medicare and Medicaid. Their efforts are required to have a particular emphasis on managing transitions between levels of care and coordination between physical and behavioral health. Full payment is based on meeting specific quality indicators. This spring, the State will implement a similar proposal for children with complex medical needs. Further, implementation of a managed care program for dual eligible beneficiaries helps the State implement the Medicaid reform law of moving 50 percent of beneficiaries from fee-for-service (FFS) to risk-based care coordination by January 1, 2015.

[9] CCEs will receive an enhanced administrative fee to coordinate care in a fee-for-service system.
[10] MCCNs will receive a capitation rate because – in addition to fulfilling the care coordination requirements required by the solicitation – the entities will bear risk for all services covered in its contract with the State.

ii. Integrated Care Program (ICP)

Implementation of the demonstration also builds upon a recent State initiative, in the counties of Suburban Cook (non-606 zip codes), DuPage, Kane, Kankakee, Lake, and Will counties, to improve care for Seniors and Adults with Disabilities, the Integrated Care Program (ICP). ICP is the State's managed care program for Seniors and Adults with Disabilities who are not eligible for Medicare, through which Enrollees receive all covered Medicaid services including acute, behavioral health, and long-term care services and supports through managed care. This program, which includes robust care coordination efforts, established a foundation for the development of the Medicare-Medicaid Alignment Initiative. Because many ICP Enrollees move into dual Medicare/Medicaid status, implementation of this alignment demonstration will provide the opportunity for the seamless coverage of individuals as their eligibility status changes.

iii. Health Homes

This proposal also fits within expected state plan activity and alignment with Affordable Care Act (ACA) initiatives. The State is planning to submit a state plan amendment (SPA) to implement the health home option offered through Section 2703 of the ACA. For the population served by this demonstration and ICP, the State will propose a model where the Plan operates as the health home.

iv. Home and Community-Based Services Waivers

In addition, the State operates nine Home and Community-Based Services (HCBS) waivers, which allow Medicaid Enrollees to receive non-traditional services in the community or in their own homes, rather than being placed in an institutional setting. Each HCBS waiver is designed for individuals with similar needs and offers a different set of services. All HCBS waivers will be renewed in CY 2012. Plans will be required to coordinate with HCBS case managers during transition and for determinations of functional eligibility for the waiver services thereafter. Four of the nine HCBS waivers the State operates are included in the demonstration. The four waivers included in the demonstration are: 1) Persons who are Elderly; 2) Persons with Disabilities; 3) Persons with HIV/AIDS; and 4) Persons with Brain Injury. More information on these can be found in *Attachment C: Home and Community Based Services* and at the following link: http://www.hfs.illinois.gov/hcbswaivers/.

v. Colbert Consent Decree

On behalf of a class of Illinois residents who are elderly, have a SMI, or have a physical disability, and are living in non-IMD[11] Nursing Facilities in Cook County, a lawsuit, Colbert verses Quinn was filed on August 22, 2007 and settled on December 20, 2011. Plaintiffs alleged that they are unnecessarily segregated and institutionalized in Nursing Facilities and forced to live with numerous other people with disabilities in violation of the ADA and the Rehabilitation Act, which require Illinois to administer services in the most integrated and appropriate setting.

The Colbert Consent Decree will begin implementation in September 2012. The decree sets forth a series of timeframes for assessment and transition to the community. In the first phase, within the first

[11] IMD refers to Institutions for Mental Disease.

30 months of implementation, 1,100 (of the estimated 16,000 – 20,000) individuals should relocate to community residency. The Consent Decree requires the Department of Healthcare and Family Services (HFS) to assure individuals have the opportunity to receive the full array of community-based services and supports in the most integrated settings, appropriate to their needs, in order to maximize individuals' independence, choice, and opportunities to develop and use independent living skills.

The proposed demonstration will serve as the vehicle for implementation of the Colbert Consent Decree for those plaintiffs and class members who are dually eligible for Medicare and Medicaid. HFS is responsible for assessing an individual's readiness for and providing the individual with options for transition to the community. For those who choose to transition to the community, and are eligible for and choose to enroll in the demonstration, Plans will designate a Colbert transition coordinator to work with HFS in care plan development and providing access to necessary Medicare and Medicaid services and supports for transition. (Individuals transitioning to the community will also have access to non-Medicaid services provided outside of the Plan that are required under the Consent Decree, such as housing subsidies.) Plans will be responsible for heightened monitoring and case management as the individual adjusts to living in the community.

IV. STAKEHOLDER ENGAGEMENT AND BENEFICIARY PROTECTIONS

a. Engagement of Stakeholders During Planning Process

The State began stakeholder engagement in the planning of managed care programs for the SPD populations in April 2010. Since then, the State held 16 planning meetings with stakeholders specific to managed care development and engaged stakeholders in topics pertinent to the development of a managed care program including consumer direction, quality outcomes and measurement, care management, enrollment, and provider networks. Examples of stakeholder feedback and lessons learned that informed the development of the proposed demonstration include a greater emphasis on ensuring consumer direction not only with respect to personal assistants but with respect to all services; to ensure network adequacy before implementation of the demonstration; to require Plans to work with providers to meet ADA compliance; and to ensure continuity of care as beneficiaries are transitioned into the program. The State also consulted with Native American organizations to ensure they are aware of the demonstration and the possible changes to the delivery of care for American Indians / Alaska Natives who are dual eligible beneficiaries.

Of the 16 planning meetings, three of the stakeholder meetings were held during the public comment period for the draft proposal (February 17 – March 19, 2012) in several cities in the geographic target areas. During these meetings the State engaged stakeholders on topics pertinent to the demonstration including the passive enrollment process, network adequacy, mandatory Medicaid managed care enrollment in the demonstration, excluding individuals receiving developmental disability institutional or community-based waiver services from enrollment in the demonstration, and allowing MCCNs to participate in the demonstration in a more limited geographical area.

Furthermore, the State actively engaged stakeholders in the Innovations Project planning process for coordinated care programs of which the demonstration is a component. In June 2011, the State released its *Coordinated Care Key Policy Issues* document through which it solicited stakeholder feedback on developing coordinated care programs. The State received 75 responses to its *Coordinated*

Care Key Policy Issues document that it used to inform the development of the Innovations Project initiatives, which includes improved care delivery for dual eligible beneficiaries.

After the State developed its framework for the Innovations Project initiatives, it hosted a kick-off meeting in October 2011 that was also available via webinar. The kick-off meeting had over 1,000 participants / webinar subscribers. Based on the information provided during the kick-off meeting, the State received over 100 questions and provided written responses to questions via its website.

The State also holds stakeholder meetings at least quarterly through the Medicaid Advisory Committee (MAC), the MAC Care Coordination Subcommittee, and the SPD stakeholder group. At these meetings, the State provides updates on the planning and implementation of the Innovations Project and other initiatives including the proposed demonstration and continues to receive stakeholder feedback on its efforts. In addition to stakeholder meetings, the State uses its website to post pertinent information related to the demonstration (http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx) and maintains an email box to be able to respond to questions and comments related to the demonstration and the other initiatives the State is pursuing (HFS.carecoord@illinois.gov).

Below is a list of methods the State used to engage stakeholder feedback including stakeholder meetings to date and the release of the *Coordinated Care Key Policy Issues* document.

Stakeholder Involvement To-Date

- SPD stakeholder meeting – March 14, 2012;
- SPD stakeholder meeting – March 7, 2012;
- SPD stakeholder meeting – February 23, 2012
- Medicaid Advisory Committee (MAC) – 1/19/12;
- MAC Care Coordination Subcommittee – 1/10/12;
- MAC Long-term Care Subcommittee – 12/16/11;
- MAC – 11/18/11;
- MAC Care Coordination Subcommittee – 11/15/11;
- Responses to Webinar Questions and Answers – 11/30/11;
- Innovations Project Kickoff (Webinar) – 10/31/11;
- Coordinated Care Key Policy Issues – June 2011; and
- 13 SPD stakeholder meetings between April 2010 and December 2012.

b. Ongoing Stakeholder Engagement

The State will maintain an active stakeholder group, the SPD stakeholder group, whose feedback is relevant to the development and operation of the demonstration. Through quarterly meetings with this stakeholder group, the State plans to continue active stakeholder involvement in the development, implementation, and operation of the demonstration including in the identification of relevant quality measures. The State welcomes ongoing feedback related to the demonstration and has a website dedicated to providing pertinent information and updates on the demonstration (http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx) as well as an email address dedicated to receiving comments on an ongoing basis. All comments, questions, or concerns can be emailed using the subject line "Dual Capitation Initiative" to the following email address: HFS.carecoord@illinois.gov.

In addition to the SPD stakeholder group and dedicated website and email address, the States proposes the following methods for continuing stakeholder involvement throughout the operation of the demonstration:

- Plans will be required to have quarterly consumer advisory board meetings. The consumer advisory board members will include Plan Enrollees, family members, legal guardians or representatives from community organizations that serve Enrollees. The consumer advisory board will elect a chairperson to serve for a designated period of time. Plans will designate staff liaisons to attend all consumer advisory board meetings. Consumer advisory board meetings will make suggestions regarding Plan policies and programs including cultural competency, member outreach plans, member education materials, prevention programs, member satisfaction surveys, and quality improvement programs;
- The State will have ongoing, quarterly stakeholder meetings to continue to receive input on the operation and success of the program including through the MAC, the MAC Care Coordination Subcommittee, and the SPD stakeholder group. The State will use this feedback as a means for determining program and contract improvements;
- The State will make stakeholder meetings available in alternative formats for individuals with disabilities, when requested; and
- In order to ensure that enrollment notices are understandable to the reader, the State intends to use the MAC Client Education Subcommittee as the stakeholder advisory committee to review and comment on enrollment notices before they are sent to beneficiaries.

Beneficiaries, their families, and caregivers are encouraged to provide ongoing feedback on the overall operation of the demonstration through the State's dedicated email address and to participate in Plan consumer advisory boards, State stakeholder meetings, and the development and implementation of Enrollee care plans to assure ongoing stakeholder involvement in the operation of the demonstration.

c. Description of Beneficiary Protections

The State carefully designed the demonstration to ensure adequate beneficiary protections. Below highlights several protections – based on stakeholder feedback – which the State plans to include in the demonstration:

- Adequate Networks: Plans will be required to establish, maintain, and report on provider networks that at least meet State Medicaid access standards for long-term care services and Medicare access standards for medical services and prescription drugs. Where there is overlap in services covered between Medicare and Medicaid, the State and CMS will negotiate and determine the appropriate network adequacy requirements. In addition, Enrollees will have a choice of providers from a broad network of providers including PCPs, behavioral health providers, specialists, ancillary providers, hospitals, pharmacists, and providers of LTSS, home care, and other community supports.

- Continuity of Care: The program will emphasize continuity of care as Enrollees are transitioned into it. The protections will go beyond the requirements for transition of care in Illinois' Managed Care Reform and Patient's Rights Act (215 ILCS 134/25, which can be found at http://www.ilga.gov/legislation/ilcs/documents/021501340K25.htm). Below lists some of the proposed continuity of care protections for Enrollees:

- In addition to a 180-day period in which Enrollees may maintain a current course of treatment with an out-of-network provider, they will be able to maintain existing PCP arrangements for 180 days and all current providers will be offered Single Case Agreements to continue to care for that Enrollee beyond the 180 days if they remain outside the network. Plans may choose to transition beneficiaries to a network provider earlier than 180 days as long as:
  - The beneficiary is assigned to a medical home that is capable of serving their needs appropriately;
  - A health risk and/or behavioral health risk assessment is complete; and
  - The Plan consulted with the new medical home and determined that the medical home is accessible, competent, and can appropriately meet the beneficiary's needs;

- All prior approvals for drugs, therapies or other services existing in Medicare or Medicaid at the time of enrollment will be honored for 90 days post enrollment and will not be terminated at the end of 90 days without advance notice to the Enrollee and transition to other services, if needed;

- Plans shall assume responsibility for an Enrollee receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment; and

- Plans shall assume full responsibility for pre-existing conditions upon effective date of enrollment.

- Self-directed care: Plans will be contractually required to provide assurances of consumer-direction throughout their care plans and service delivery model. Enrollees must be allowed to participate in their own care plan development, including the selection of providers and services to receive or not receive. Plans must encourage providers to support Enrollees in directing their own care and Enrollee Care Plan development.

  The right of Enrollees to select their own personal assistants will be preserved and protected. Personal assistants will be guaranteed a fair wage. The State expects Plans will institute quality and integrity controls to be in place over personal assistants.

- Enrollee Rights: Plans must ensure the Enrollee's right to:

  - Be treated with respect and consideration for their dignity and privacy;
  - Receive information on available treatment options and alternatives, presented in a manner appropriate to the their condition and ability to understand;
  - Participate in decisions regarding their health care, including the right to refuse treatment;
  - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
  - Request and receive a copy of their medical records, and to request that they be amended or corrected; and
  - Exercise their rights, and that the exercise of those rights will not adversely affect the way they are treated.

- Grievance and Appeals Processes: The State and CMS will develop unified grievance and appeals processes. The appeals process will include an exhaustion of the Plan's internal appeals process prior to review by the Medicare-qualified external independent contractor.

- Privacy: The State will ensure the privacy of Enrollee health records and ensure access by Enrollees to such records.

- Communication: Plans will be required to meet the following requirements for all communications with Enrollees including but not limited to marketing and outreach materials, basic health plan information, Enrollee health education campaigns, and telephone access:

    - Written documents shall be at a sixth grade reading level;
    - Plans will offer alternative methods of communication (Braille, sign language, etc.) as well as translated materials; and
    - All Enrollee material shall require CMS and State approval prior to use.

  The State intends to work with CMS to develop a concurrent review process for Plan materials.

- Cultural Competency: To ensure all covered services are provided in a culturally competent manner, Plans will be required to implement a cultural competence plan that meets NCQA standards for Culturally and Linguistically Appropriate Services in Health Care. Plans will ensure the cultural competence of providers and all staff and provide training as appropriate engaging local organizations to develop and provide the relevant training. Plans will ensure the availability of interpretive services.

V. FINANCING AND PAYMENT

a. Financial Alignment Model

The program will use a full-risk capitation model for the full range of Medicare and Medicaid (both state plan and HCBS waiver) services. The State will make monthly payments to Plans for the Medicaid portion of the capitation rate. CMS will make monthly payments to Plans for the Medicare portion of the capitation rate including Part D.

Rates for participating Plans will be developed by the State in partnership with CMS based on baseline spending in both programs and anticipated savings that will result from integration and improved care management. The State is working with CMS to develop a risk adjustment methodology. Rate cells will be designed to incentivize Plans to provide services in the least restrictive setting, move beneficiaries into the community when appropriate, and cover one-time transition costs for people moving out of institutions into the community. The Part D portion of the rate will be based on the standardized national average bid amount and will be risk adjusted in accordance with the rules that apply for all other Part D plans.

The State expects to provide flexibility in creating benefit packages by allowing Plans to provide supplemental services not otherwise covered under Medicare or Medicaid, as long as the services are provided under the blended Medicare and Medicaid capitation rate. The State expects the flexibility in

creating a benefit package combined with economic incentives through the rate setting process to help increase access to HCBS services, when appropriate.

b. Incentive Payment Plan

The State proposes to implement a pay-for-performance (P4P) structure similar to that in the ICP. The State will withhold a specified percentage from capitated payments on a monthly basis, which Plans will be eligible to receive as an incentive payment for meeting specific quality measure (P4P) targets. Plans will be required to meet P4P targets annually in addition to a minimum performance standard to earn incentive payments. Each measure will have an equal share of the incentive payment associated with it.

The State proposes that, in year one, P4P measures will focus on administrative process and access to services. Subsequent years will focus on quality measures.

Below lists the total amounts proposed to be withheld from the monthly capitated payments per demonstration year:

- Year One: 1%
- Year Two: 1.5%
- Year Three: 2%

c. Quality Measures

In order to compare performance across State initiatives for similar populations, the State plans to measure Plan performance using at a minimum the ICP quality measures applicable to the demonstration population. See *Attachment A* for a list of the ICP quality measures, and the proposed P4P measures for demonstration years 2 and 3. The State will work with CMS to add to this list of measures to reflect quality measures appropriate to the population and to meet other federal requirements, as necessary.

In addition, the State will work with CMS to finalize the quality measures that will be used as pay-for-performance (P4P). The State will also work with CMS to identify P4P baselines and annual targets.

Finally, the State will jointly develop with CMS a single, comprehensive quality management and consolidated reporting process. The State along with CMS will require the development of an ongoing quality improvement program including performance improvement projects.

d. Payments to Providers

Plans will be asked to propose creative payment plans that encourage a holistic approach to beneficiary care, quality outcomes and evidence-based practice such as bundled payments for episodic specialty care. Safeguards will be in place to ensure full encounter data is received from any capitated entity. Plans will be encouraged to propose payment structures for medical homes that include a balanced combination of capitation, fee-for-service and pay-for-performance to encourage care coordination,

preventive care and maintenance of chronic conditions. The State will review and monitor use of innovative Plan strategies to ensure there are no unintended consequences.

Plans will be required to reimburse out-of-network providers the Medicare or Medicaid FFS rate for ER services. The State is working with CMS to finalize the payment structure for other out-of-network services. The State is also working with CMS to finalize Federally Qualified Health Center (FQHC) reimbursement under the demonstration.

VI. EXPECTED OUTCOMES

a. State ability to monitor, collect and track data on quality and cost outcome metrics

The Department of Healthcare and Family Services (HFS) has a knowledgeable staff within the Bureau of Managed Care with many years experience monitoring and tracking Medicaid quality and cost data including with the ICP and the State's voluntary managed care programs. HFS will build upon this experience and infrastructure to develop a quality and cost measurement program and strategy for the Medicare-Medicaid Alignment Initiative. The State is hiring additional personnel in quality, encounter data collection, and data analytics to provide additional capacity to monitor, collect, and track data on quality and cost outcomes in the proposed demonstration.

The State has a state-of-the-art data warehouse and is adding analytical tools to allow the State to more fully analyze and track data related to the proposed demonstration. HFS recently hired an in-house actuary as Director of Data and Research. It is hiring qualified personnel to fill several new positions in the Office of Data Research and Management. This office will be able to analyze managed care organization (MCO) encounter data for service concerns, to track improvements in care coordination, and to monitor costs. In addition, HFS is hiring an additional senior manager in its Bureau of Technical Support to oversee MCO encounter data to ensure full data is submitted and captured. Another new position of MCO Rate and Finance has been created to help analyze MCO costs and savings.

The State will share data with CMS to inform program management, rate development and evaluation. Furthermore, the State will require Plans to collect and report encounter data using a uniform encounter reporting method to be developed by the State and CMS.

HFS is enhancing its quality monitoring staff with the development of a dedicated bureau for managed care quality. HFS is conducting a nationwide search for a Bureau Chief and a senior manager to focus on MCO quality. On an operational level, the ICP quality measures are already programmed in the State's data warehouse, which will help to create a smooth transition when implementing the Medicare-Medicaid Alignment Initiative quality program.

Below lists the State's experienced managed care administration, quality, and cost data teams and new positions that will augment the State's existing ability to oversee the demonstration.

<u>Medicare-Medicaid Alignment Initiative Management and Quality Team</u>

- James Parker, Deputy Administrator

- Chief, Bureau of Managed Care – Michelle Maher
    - Laura Ray, Manager of MCO operations
        - Peggy Mounce, Supervisor of MCO Contracts Compliance
        - Peggy Luster, MCO Operations Specialist
    - Amy Mihalich, Manager of Managed Care Information Systems
        - Michelle Furlong, Managed Care Information Systems Specialist
    - Lauren Tomko, Manager of Integrated Care Operations
    - Ellen Amerson, Manager of Managed Care Quality
    - Manager of MCO Contracts and Compliance (New Hire)

- Chief, Bureau of Quality Management (New Hire)
    - Manager of Managed Care Quality (New Hire)

- Manager, Medicare/Medicaid Coordination (New Hire)

- Manager, Data Quality Assurance (New Hire)

Medicare-Medicaid Alignment Initiative Data Team

- Tia Sawhney, Director of Data and Research
    - Sophia Newman, Technical Writer
    - Manager, Data Analytics Unit (New Hire)

- Director of Encounter Data Program (New Hire)

b. Expected impact on Medicare and Medicaid costs

The State expects an integrated program to result in improved quality of care for dual eligible beneficiaries. Through improved care coordination and reduced cost shifting incentives between Medicare and Medicaid, the State's goal is to ensure access to all Medicare and Medicaid benefits and comprehensive services that address the Enrollees' full range of needs and improve utilization of appropriate and cost-effective services including community-based services. As such, the State expects:

- An increase in the number of beneficiaries participating in and receiving care coordination;
- An increase in the number of health risk and behavioral health screenings;
- An increase in the number of beneficiaries with care plans;
- Improved access to HCBS waiver and other supportive services;
- Reduced hospital readmissions, inappropriate emergency room utilization, and non-emergency transportation costs particularly for nursing home residents; and
- Improved beneficiary satisfaction.

According to a 2011 CMS report, Illinois is among the highest – sixth highest – in potentially avoidable hospital readmission rates among dual eligible beneficiaries nationally.[12] Additionally, according to CMS, Illinois is among the highest in institutional payments and lowest in HCBS spending as a percentage of all long-term care spending.[13] Using federal fiscal year (FFY) 2009 data, the CMS analysis indicates that Illinois had the eighth highest level of institutional payments nationally and the third lowest rate nationally of HCBS spending as a percentage of all long-term care spending in the State.[14] While this information is not specific to dual eligible beneficiaries, full dual eligible beneficiaries accounted for approximately 67.8 percent of all long-term care (institutional and HCBS) spending in Illinois Medicaid in 2010. Furthermore, according to State estimates, full dual eligible beneficiaries accounted for approximately 50.1 percent of all nonemergency medical transportation costs in the State in 2010. These statistics indicate that there is need in Illinois to improve care delivery for dual eligible beneficiaries and to shift long-term care utilization from institutions to the community, as appropriate.

The federal government contracted with Mercer to perform an analysis of the demonstration and to provide detailed financial Medicare and Medicaid projections over the next three years, including estimates of how much savings are anticipated. Therefore, detailed financial projections and further analysis of cost savings will be provided at a later date.

VII. INFRASTRUCTURE AND IMPLEMENTATION

a. State Infrastructure/Capacity

HFS has a knowledgeable staff within the Bureau of Managed Care with many years experience implementing and monitoring the State's voluntary managed care programs, the Primary Care Case Management Program (PCCM), disease management program, and the ICP, which provide care to approximately 78% of Illinois Medicaid recipients. The State's managed care team has experience in managed care implementation and administration including conducting contract negotiations and rate setting and monitoring contract compliance, quality data, and encounter data reporting.

In addition, the State is hiring personnel in managed care administration and data analytics including expertise in Medicare to provide additional capacity to monitor contract compliance and otherwise implement the proposed demonstration. See *Section VI: Expected Outcomes* for a description of the demonstration team.

b. Expected Use of Contractors

The State will use an External Quality Review Organization (EQRO) to complete compliance reviews, validate performance measures, validate performance improvement projects, and provide technical

[12] Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligibles and Potentially Avoidable Hospitalizations.
http://www.cms.gov/reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf
[13] Centers for Medicare & Medicaid Services: Patient Protection and Affordable Care Act Section 10202 State Balancing Incentive Payments Program Initial Announcement.
http://www.cms.gov/smdl/downloads/Final-BIPP-Application.pdf
[14] Ibid.

assistance as needed. The State is in the process of procuring a new EQRO contract and the State will include the responsibilities associated with the demonstration in the RFP. The CMS contractor will complete readiness reviews targeted for July – September 2012.

A client enrollment broker (CEB), under contract with the State, will develop and run an algorithm to run assignments for the auto-enrollment process. The assignments will be carried out by the State and CMS.

In addition, the Department expects to contract with UIC to conduct an independent evaluation of the demonstration similar to that performed for the ICP. The State will require UIC to consult with beneficiaries in its evaluation and develop measures related to LTSS and consumer satisfaction. The State will make the results of this evaluation publicly available. This evaluation will be in addition to the statutorily required CMS evaluation.

c. Overall Implementation Strategy and Anticipated Timeline:

Timeframe	Key Activities/Milestones	Responsible Parties
Feb 17 – Mar 19	State posts proposal for 30 days	IL
April 6	State submits proposal to CMS	IL
Apr 9 – May 8	CMS posts proposal for 30 days	CMS
Apr 30	Medicaid RFP Release	IL /CMS
May 24	Medicare applications due to CMS	Plans
Jun 15	Medicaid Proposals Due	Plans
July 31	Plan selections announced	IL /CMS
July – Sept	Readiness Reviews	IL /CMS
Aug 1	Hiring program staff complete	IL
Sept 1	State Plan Amendment (SPA) (to implement voluntary Medicaid managed care for dual eligible beneficiaries) submitted to CMS	IL
Dec 1	SPA approved	CMS
Sept 20	Contracts signed	IL /CMS /Plans
Oct 1	Enrollment materials sent to beneficiaries	IL /CMS

Timeframe	Key Activities/Milestones	Responsible Parties
Oct 15 – Dec 7	Open Enrollment	CEB/CMS
Oct 15 – Nov 15	System Changes complete / Testing begins	IL
Jan 1, 2013	Enrollment effective date	
Jan, 2013 and beyond	Contract monitoring and compliance Stakeholder feedback	IL /CMS/Plans

VIII. FEASIBILITY AND SUSTAINABILITY

a. Potential barriers/challenges and/or future State actions

The State does not anticipate potential barriers, challenges, or necessary future State actions in order to implement the proposed demonstration.

b. Statutory and/or regulatory changes needed

The State does not anticipate needing statutory or regulatory changes to implement the proposed demonstration.

c. New State funding commitments or contracting processes necessary

The State does not anticipate new funding commitments or changes to its current contracting processes in order to implement the demonstration. Under its' existing contracting processes, the State is in the process of procuring a new CEB that will be responsible for enrollment functions under the demonstration and a new EQRO. The State recently released the CEB RFP and expects to release the EQRO RFP in the near future.

d. Scalability and replicability of the proposed model

The State will test the demonstration in the select geographic areas and hopes to determine replicability in other areas of the State through evaluation of program success (e.g. achievement of quality measures goals; cost measurement). To assist in these efforts, the Department expects to contract with an outside entity to conduct an independent evaluation of the demonstration with consumer input similar to that performed by the UIC for the ICP.

IX. ADDITIONAL DOCUMENTATION

a. List of State Plan Amendments

The State anticipates submitting the following State Plan Amendments:

- To allow dual eligible beneficiaries into voluntary Medicaid managed care; and
- Health Homes.

X. ATTACHMENTS

a. Attachment A: Quality and Pay-for-Performance Measures

#	Category	Quality Measure	Specification Source	Proposed P4P Measures
1	**Behavioral Health Risk Assessment and Follow-up**	New Enrollees who completed a behavioral health assessment (BHRA) within 60 days of enrollment. Also measures percent of Enrollees with a positive finding on BHRA who receive follow-up with MH provider within 30 days of assessment		
	1) Behavioral Screening/ Assessment within 60 days of enrollment		State	
	2) Behavior Health follow-up within 30 days of screening		State	
2	**Alcohol and other Drug Dependence Treatment**	Enrollees with new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	HEDIS®	
3	**Behavioral Health Support**	Appropriate follow-up with any Provider within 30 days after initial BH diagnosis.	State	Years 2, 3
4	**Behavioral Health Support**	Follow-up after hospitalization for Mental Illness		
	1) Follow-up in 7 days		HEDIS®	
	2) Follow-up in 30 days		HEDIS®	Years 2, 3
5	**Care Coordination Influenza Immunization Rate**	Enrollees who received at least one influenza immunization annually.	State	
6	**Dental Utilization**	Enrollees who receive an annual dental visit		
	1) Annual Dental Visit –All		State	
7	**Dental ER Utilization**	Emergency room visits for Enrollees with dental primary diagnoses.	State	
8	**Diabetes Care**	Increased utilization of disease specific therapies. Meet two of numbers 1, 2, and 3 and one of numbers 4 and 5.		

a. Attachment A: Quality and Pay-for-Performance Measures

#	Category	Quality Measure	Specification Source	Proposed P4P Measures
	1) HbA1c testing 1x per year		HEDIS®	Years 2, 3
	2) Microalbuminuria testing 1 X per year		HEDIS®	Years 2, 3
	3) Cholesterol testing 1X per year		HEDIS®	Years 2, 3
	4) Statin Therapy 80% of the time		State	Years 2, 3
	5) ACE/ARB 80% of the time		State	Years 2, 3
9	**Congestive Heart Failure**	Increased utilization of disease specific therapies (meet 2 of 3).		
	1) ACE/ARB 80% of the time		State	Years 2, 3
	2) Beta Blocker 80% of the time		State	Years 2, 3
	3) Diuretic 80% of the time		State	Years 2, 3
10	**Coronary Artery Disease**	Increased utilization of disease specific therapies (meet 2 of 4).		
	1) Cholesterol testing 1X per year		HEDIS®	Years 2, 3
	2) Statin Therapy 80% of the time		State	Years 2, 3
	3) ACE/ARB 80% of the time		State	Years 2, 3
	4) Beta Blocker Post MI for 6 months following MI		HEDIS®	Years 2, 3
11	**Chronic Obstructive Pulmonary Disease**	Increased utilization of disease specific therapies (meet 2 of 3).		
	1) Acute COPD Exacerbation w/corticosteroid		HEDIS®	Years 2, 3
	2) History of hospitalizations for COPD with a bronchiodilator medications		HEDIS®	Years 2, 3
	3) Spirometry testing (1 time in last three years)		HEDIS®	Years 2, 3

a. Attachment A: Quality and Pay-for-Performance Measures

#	Category	Quality Measure	Specification Source	Proposed P4P Measures
12	**Ambulatory Care**	Emergency Department visits per 1,000 Enrollees	HEDIS®	Years 2, 3
13	**Ambulatory Care follow-up after Emergency Department Visit**	Follow-up with any Provider within 14 days following Emergency Department visit	State	Years 2, 3
14	**Inpatient Utilization-General Hospital/ Acute Care**	General Hospital Inpatient Utilization Admits per 1,000 Enrollees	HEDIS®	
15	**Mental Health Utilization**	Mental Health services utilization per 1,0000 Enrollees	HEDIS®	
16	**Ambulatory Care Follow-up after Inpatient Discharge**	Ambulatory care follow-up visit within 14 days of every inpatient discharge	State	Years 2, 3
17	**Inpatient Hospital Re-Admission**	Inpatient Hospital 30-day readmissions. In addition, Mental Health readmissions reported separately	State	Years 2, 3
18	**Long Term Care Residents – Urinary Tract Infection Hospital Admission**	Hospital Admissions due to urinary tract infections for LTC Residents	AHRQ	
19	**Long Term Care Residents – Bacterial Pneumonia Hospital Readmission**	Hospital Admission due to bacterial pneumonia for LTC Residents	HSAG	
20	**Long Term Care Residents – Prevalence of Pressure Ulcers**	LTC Residents that have category/ stage II or greater pressure ulcers.	State	Year 3
21	**Medication Reviews**	Annual monitoring for Enrollees on persistent medications	HEDIS®	
22	**Medication Reviews**	Antidepressant Medication Management - At least 84 days continuous treatment with antidepressant medication during 114 day period following Index Episode Start Date (IESD)	HEDIS®	Years 2, 3
23	**Medication Reviews**	Antidepressant Medication Management - At least 180 days continuous treatment with antidepressant medication during 231 day period following IESD	HEDIS®	Years 2, 3
24	**Medication Reviews**	Percentage of Enrollees diagnosed with schizophrenia who maintain medication adherence at 6 months and 12 months	State	

a. Attachment A: Quality and Pay-for-Performance Measures

#	Category	Quality Measure	Specification Source	Proposed P4P Measures
25	**Preventive Services**	Colorectal Cancer Screening	HEDIS®	
26	**Preventive Services**	Breast Cancer Screening	HEDIS®	
27	**Preventive Services**	Cervical Cancer Screening	HEDIS®	
28	**Preventive Services**	Adult BMI Assessment	HEDIS®	
29	**Access to Enrollee's Assigned PCP**	Enrollees who had an annual ambulatory or preventive care visit with Enrollee's assigned PCP.	State	Years 2, 3
30	**Retention Rate for LTC and HCBS Waiver Enrollees Service in the Community**	LTC and HCBS Waiver Enrollees served in the community at the beginning of the year and continued to be served in the community during the year.	State	Years 2, 3

b. Attachment B: Medicaid Covered Services[15]:

- Advanced Practice Nurse services;
- Ambulatory Surgical Treatment Center services;
- Audiology services;
- Chiropractic services;
- Limited diagnostic, restorative, and treatment dental services per the Medicaid State Plan;
- Family planning services and supplies;
- FQHCs, RHCs and other Encounter rate clinic visits;
- Home health agency visits;
- Hospital emergency room visits;
- Hospital inpatient services;
- Hospital ambulatory services;
- Laboratory and x-ray services;
- Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
- Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option;
- Nursing Facility services;
- Optical services and supplies;
- Optometrist services;
- Palliative and Hospice services;
- Pharmacy Services;
- Physical, Occupational and Speech Therapy services;
- Physician services;
- Podiatric services;
- Post-Stabilization Services;
- Renal Dialysis services;
- Respiratory Equipment and Supplies;
- Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390 and 77 Ill. Admin. Code Part 2090; and
- Transportation to secure Covered Services.

[15] Attachment B lists all Medicaid State Plan services. For dual eligible beneficiaries, Medicare is the primary payer for many of the services.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Adult Day Service	x	x	x	x	Adult day service is the direct care and supervision of adults in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting.	**DOA:** 89 Il. Adm. Code 240.1505-1590 Contract with Department on Aging, Contract requirements, **DRS:** 89 Il. Adm. Code 686.100	**DOA, DRS** The amount, duration, and scope of services is based on the service plan and is included in the service cost maximum/monthly cost limit. This service will not be duplicative of other services in the Waiver.
Adult Day Service Transportation	x	x	x	x	Agency provision or arrangement of transportation, with at least one vehicle physically accessible, to enable clients to receive adult day care service at the adult day care service provider's site and participate in sponsored outings.	**DOA:** 89 Il. Adm. Code 240.1505-1590 **DRS:** 89 Il. Adm. Code 686.100	**DOA:** Services are provided according to the plan of care within the service cost maximum. **DRS:** Will provide a maximum of two one-way trips per day.
Case Management (Administrative Claim)	x	x	x	x	Case management includes services that assist participants in gaining access to needed MFP, waiver and state plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. Responsibilities include assessment, care plan development and ongoing monitoring and review.	**DOA:** 89 Il. Adm. Code 240.1430 **DRS PD:** 89 Il. Adm. Code 220.605 **DRS BI and HIV:** http://www.ilga.gov/commission/jcar/admincode/089/08900686sections.html	

DoA: Department on Aging
DHS-DRS: Department of Human Services – Division of Rehabilitation Services

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Community Transition Services	X (MFP only)	X (MFP only)			Community transition services are non-recurring set-up expenses for MFP participants who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to establish a basic household but that do not constitute room and board.	Enrolled vendor approved by the Service Facilitator and the participant/guardian	One-time transition services are viewed mainly to be one-time costs. In the event that the MFP participant should need the services after the twelve (12) month period of Money Follows the Person eligibility, Flexible Senior Spending (FSS) funds are available for the MFP participant's needs. No more than $4,000 maximum may be spent per participant on Community Transition Services without the prior approval of the Community Reintegration Program (CRP) Manager or designee.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Environmental Accessibility Adaptations-Home	X (MFP only)	x	x	x	Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct remedial benefit to the participant.	**DOA and DRS:** 89 Il. Adm. Code 686. 705(d)	**DOA – MFP Only** Requests for Home Modifications in excess of the $3,000 limit will be considered on a case-by-case basis by IDOA. Requests for Assistive technology in excess of the $1,000 limit will be considered on a case-by-case basis by IDOA. **DRS** Environmental Accessibility Adaptations may be provided to a customer if the total cost for purchase of all environmental modifications and assistive equipment purchases, rentals, and repairs does not exceed $25,000 over 5 years.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Supported Employment				x	Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. It may include assisting the participant to locate a job or develop a job on behalf of the participant, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.	**DHS:** 89 Il. Adm. Code 530	**BI** When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting. The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Home Health Aide (Extended state plan service)		x	x	x	Service provided by an individual that meets Illinois licensure standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid state plan shall not be applicable.	**DRS:** Individual: 210 ILCS 45/3-206 Agency: 210 ILCS 55	Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Nursing, Intermittent (Extended state plan service)		x	x	x	Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the state. Nursing through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs. Intermittent nursing waiver services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.	**DRS:** Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.
Nursing, Skilled (RN and LPN) (Extended state plan service)		x	x	x	Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.	**DRS:** Home Health Agency: 210 ILCS 55 Licensed Practical Nurse: 225 ILCS 65 Registered Nurse: 225 ILCS 65	**DRS** The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Occupational Therapy (Extended state plan service)		x	x	x	Service provided by a licensed occupational therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Occupational therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs	**DRS:** Occupational Therapist: 225 ILCS 75 Home Health Agency: 210 ILCS 55	**DRS** All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level.
Physical Therapy (Extended state plan service)		x	x	x	Service provided by a licensed physical therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Physical therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.	**DRS:** Physical Therapist 225 ILCS 90 Home Health Agency: 210 ILCS 55	**DRS** All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Speech Therapy (Extended state plan service)		x	x	x	Service provided by a licensed speech therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Speech therapy through the waiver focuses on long term habilitation needs rather than short-term acute restorative needs.	**DRS:** Speech Therapist 225 ILCS 110 Home Health Agency: 210 ILCS 55	**DRS** All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Prevocational Services				x	Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Prevocational Services are provided to persons expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).	89 Il. Adm. Code 530	The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Habilitation-Day				x	**BI** Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility which the individual resides. The focus is to enable the individual to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.	**BI** 59 Il. Adm. Code 119	**BI** The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score. This service shall be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in the individual's plan of care.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Homemaker	x	x	x	x	Homemaker service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist individuals with their activities of daily living, including personal care, as well as other tasks such as laundry, shopping, and cleaning. The purpose of providing homemaker service is to maintain, strengthen and safeguard the functioning of MFP participants in their own homes in accordance with the authorized plan of care.	**DOA:** 89 Il. Adm. Code 240 **DRS:** 89 Il. Adm. Code 686.200	**DOA:** Service is limited by the service cost maximum, except for transport. There is a maximum of 100 hours a month. **DRS:** This service will only be provided if personal care services are not available or are insufficient to meet the care plan or the consumer cannot manage a personal assistant. The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level.
Home Delivered Meals		x	x	x	Prepared food brought to the client's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten later. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself.	89 Il. Adm. Code 686.500	The amount, duration, and scope of services is based on the determination of need assessment conducted by the HSP counselor or case manager and the service cost maximum determined by the DON score.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Personal Assistant		x	x	x	Personal Assistants provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the consumer's family. Personal care providers must meet state standards for this service. The personal assistant is the employee of the consumer. The state acts as fiscal agent for the consumer.	89 Il. Adm. Code 686.10	The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. Personal care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the personal care provider and the service is not otherwise covered.
Personal Emergency Response System (PERS)	x	x	x	x	PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.	**DOA:** Standards for Emergency Home Response 89 Il. Adm. Code 240 **DRS:** 89 Il. Adm. Code 686.300	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

DoA: Department on Aging
DHS-DRS: Department of Human Services – Division of Rehabilitation Services

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Respite		x	x	x	DRS Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer. Services are limited to personal assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.	Adult Day Care 89 Il. Adm. Code 686.100 Home Health Aide 210 ILCS 45/3-206 RN/LPN 225 ILCS 65 Home Health Agency: 210 ILCS 55 Homemaker 89 Il. Adm. Code 686.200 PA 89 Il. Adm. Code 686.10	**DRS** The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level. Services are limited to personal assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Specialized Medical Equipment and Supplies		X	x	x	Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. All items shall meet applicable standards of manufacture, design and installation.	**DRS:** 68 Il. Adm. Code 1253 Pharmacies 225.ILCS.85 Medical Supplies 225.ILCS.51	**DRS:** Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual. The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level.
Supportive Living Facilities (In another waiver)					An affordable assisted living model administered by the Department of Healthcare and Family Services that offers frail elderly (65 and older) or persons with disabilities (22 and older) housing with services.	89 Il Admin Code 146.215	Frail elderly between the ages of 60 and 64 would not be eligible for SLF residency due to the program's minimum age requirement of 65.

c. Attachment C: Home and Community Based Services

	DoA		DHS-DRS				
Service	**Persons who are Elderly**	**Persons with Disabilities (PD)**	**Persons with HIV/AIDS**	**Persons with Brain Injury (BI)**	**Definition**	**Standards**	**Service Limits**
Behavioral Services (M.A. and PH.D)				x	Behavioral services provide remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the recipient. These services are designed to assist customers in managing their behavior and cognitive functioning and to enhance their capacity for independent living.	Speech Therapist 225 ILCS 110/ Social Worker 225 ILCS 20/ Clinical Psychologist 225 ILCS 15/ Licensed Counselor 225 ILCS 107/	The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level. The services are based on a clinical recommendation and are not covered under the State Plan.