Integrated Care Program
Frequently Asked Questions

What is the Integrated Care Program?

The Integrated Care Program (ICP) was Illinois’ first Medicaid Managed Care Program; it began in May of 2011. ICP was created by the Illinois Department of Healthcare and Family Services (HFS) in collaboration with the Illinois Department of Human Services (DHS), and the Illinois Department on Aging (IDOA), to provide managed care services to older adults and people with disabilities on Medicaid only (not on Medicare). Through ICP, the state pays managed care organizations (MCO’s) capitated payments to provide health coverage to members, and the MCO pays the health care providers who provide services to their members. ICP is currently operating in select geographic areas of Illinois.

ICP members receive all of the same benefits and services that traditional Medicaid covers. Managed Care Organizations (MCO’s) are responsible for covering members’ medical, hospital care, prescriptions, mental health, behavioral health, and long term services and supports (LTSS). In addition, care coordination is provided by the MCOs.

ICP is mandatory; people who are eligible for ICP are required to enroll into the program and choose a plan on their own; otherwise they are automatically enrolled into a plan.

Who does the ICP affect?

The Integrated Care Program affects individuals who meet the following criteria:

- Live in one of the project areas: Cook, DuPage, Kane, Kankakee, Lake, and Will Counties, Rockford area, Central Illinois, Quad Cities, and Metro East AND

- Are an older adult or adult with a disability (19 and older) receiving benefits through Aid to the Aged Blind and Disabled (AABD) Medicaid OR Health Benefits for Workers with Disabilities (HBWD) Medicaid
ICP excludes the following people, even if they receive AABD or HBWD Medicaid:

- People with Medicare (individuals eligible for Medicare Part A or enrolled in Medicare Part B)
- Children under 19 years of age
- Individuals who are receiving temporary medical benefits
- Individuals who are eligible for Medicaid Spenddown
- Individuals who have other (non-Medicaid) insurance that covers hospital and doctor visits
- Individuals who are American Indian/Alaskan Native (may choose to voluntarily enroll)
- Women in the Illinois Breast and Cervical Cancer program

What services are covered under the ICP?

ICP members receive all of the same services that they previously received with traditional Medicaid. Managed Care Organizations (MCO’s) are responsible for covering medical, hospital, and prescription coverage, as well as mental/behavioral health services and long term services and supports (LTSS). LTSS services include services provided in a long term care facility and services provided through Medicaid Home and Community Based Service waivers (HCBS). HCBS waivers allow participants to receive LTSS in their own homes, instead of having to move into a long term care facility to receive those services. The HCBS waiver programs covered by ICP include Aging (Community Care Program), Disability, AIDS, Traumatic Brain Injury, and Supportive Living Facilities.* In addition to the services already listed here, MCO’s have the option to cover additional services if they choose.

Once an individual has selected or is auto-enrolled into an MCO, s/he will be assigned to a care coordinator through that plan. The care coordinator will assess the client’s needs and work with the client to coordinate and maintain his/her plan of care.

ICP members do not need to use their Medicaid card to receive services; instead, they will receive a separate health and benefits card from the MCO that has that plan’s information. However, ICP members are encouraged to hold on to their Medicaid card for future reference.

*Please note that the ICP does not currently cover home and community-based services for people with developmental disabilities (DD). If an ICP member receives home and community-based services through the DD Medicaid Waiver Program, those services will continue to be covered by traditional fee-for-service Medicaid. All of the individual’s other health care services will be covered by his/her ICP MCO.
What are an ICP member’s enrollment and disenrollment options?

Enrollment in ICP is mandatory. Members can choose a plan or be automatically enrolled into one if no choice is made. Members will receive a letter approximately 30 days before their official enrollment period begins to explain their options and provide a list of their plan choices. ICP members have an initial enrollment period of 60 days to choose a plan or they will be automatically enrolled into one. Upon the beginning of their plan’s coverage, members will be allowed to switch plans within the first 90 days. Individuals who opt to switch plans will then have an additional 90 day period to switch back to the original plan if they choose. However, after the 90 day period, members will be locked into the plan of their choice for the next 12 months. After the 12 months, members will again have a 60 day open enrollment period (OEP) to switch plans if they should desire.

In addition to choosing an ICP plan, members will have to choose a Primary Care Physician (PCP) who will oversee care and provide referrals for additional services. If an individual is forced to change PCP’s because of their ICP enrollment (or because their PCP leaves their ICP plan’s network) and their PCP accepts a different ICP plan, the individual can request a “for cause” plan switch outside of their regular enrollment periods by contacting Client Enrollment Services at (877)912-8880. These requests are considered on a case-by-case basis.

Which plans may I choose from and how do I compare my options?

The Illinois Client Enrollment Services website (http://enrollhfs.illinois.gov/) lists ICP MCO plan details, including provider networks and covered services. An individual’s choice of plans will vary by geographic area. Client Enrollment Service representatives are available to help educate enrollees, provide unbiased information about their health plan choices, and assist with enrollment into a health plan. Individuals can enroll in ICP through the Client Enrollment Services website listed above or by contacting Client Enrollment Services at (877)912-8880.

While Client Enrollment Services is able to provide network information for each of the ICP plans, we recommend that clients contact their health care providers to verify that those providers will accept the person’s desired ICP plan.

What are the MCO plans available?

Suburban Cook County (currently excludes city of Chicago), DuPage, Kane, Kankakee, Lake and Will counties:
- Aetna Better Health
- IlliniCare Health Plan

Updated April 2015   3
Rockford region, Winnebago, Boone, and McHenry counties
- Aetna Better Health
- IlliniCare Health Plan
- Community Care Alliance of Illinois (MCCN)

Central Illinois region
- Molina Healthcare
- Meridian Health Plan of Illinois
- Health Alliance

McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford and Menard counties
- Molina Healthcare
- Macon County Care Coordination (CCE)
- Health Alliance

Metro east region, Madison, Clinton and St. Clair counties
- Meridian Health Plan of Illinois
- Molina Healthcare

Quad city region, Rock Island, Mercer and Henry counties
- IlliniCare Health Plan
- Precedence CCE (CCE)

Chicago
- Aetna Better Health
- IlliniCare Health Plan
- Meridian Health Plan of Illinois
- HealthSpring of Illinois
- Humana Health Plan
- Blue Cross/Blue Shield of Illinois

What if my healthcare provider is not in the plan’s network?

If an individual is seeing a provider that is not in his/her ICP plan’s network, s/he will have a 90 day transition period to continue ongoing treatment with an existing provider, even if that provider is not in the ICP plan’s network. The MCO must cover services provided by the out of network provider during these 90 days (as long as the provider is willing to bill the MCO for those services). This transition period provides time for the provider to join the plan’s network or the client to find a different provider within the health plan’s network. ICP members have 180 day transition period for LTSS providers (long term care facility or HCBS services).
Where can I go for more information?

For more information about the Integrated Care Program, please visit:

- Client Enrollment Services: [http://enrollhfs.illinois.gov](http://enrollhfs.illinois.gov) (877)912-8880
- HFS website – Care Coordination: [http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx](http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx)
- MMW website with Medicaid Managed Care resources [http://www.ageoptions.org/services-and-programs_MMW-MedicaidandManagedCare.html](http://www.ageoptions.org/services-and-programs_MMW-MedicaidandManagedCare.html)

**Integrated Care Program**

**Key Terms**

**Capitated Payment** – a form of payment in which an entity is paid a flat amount (per member/individual) to provide care or coverage, regardless of how many services those members actually use in a period of time. Capitated payment is the opposite of “fee for service,” in which providers receive individual payments for each specific service that is performed.

**Care Coordination** - a method of managing a patient’s health care in which an individual (or in some cases, a team of individuals) helps a patient organize and streamline their care. In a care coordination model, a “Care Manager” or “Care Coordinator” may communicate with the patient’s health care providers to ensure that the patient receives all of the information and care they need, and that the care being received from different providers is not duplicated or conflicting. The Care Manager/Care Coordinator may also provide ongoing follow-up with the patient to ensure that the patient understands what s/he needs to do to manage his/her health conditions.

**Home and Community Based Services** (HCBS) – supportive services that are offered to individuals in their homes. The goal of providing HCBS services is generally to help enable individuals to continue living in the community, instead of needing to move into a long term care facility to receive long term services and supports. (See definition of long term services and supports below.) For more information about the home and community based Waiver programs in Illinois, visit the Department of Healthcare and Family Services website here: [http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx](http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx)
Long Term Services and Supports (LTSS) - care that helps individuals perform activities of daily living (eating, cooking, bathing, getting dressed, cleaning, etc.) This care may be provided in a long term care facility or through home and community based services. In Illinois, many individuals receive home and community based LTSS services through Medicaid “Waiver” programs (such as the Community Care Program for older adults). These programs provide a variety of in-home supports to older adults, people with disabilities, and individuals with specific conditions, such as brain injuries or HIV/AIDS. For more information about the home and community based Waiver programs in Illinois, visit the Department of Healthcare and Family Services website here: http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx

Managed Care – a method of financing and delivering health care that uses a variety of techniques improve to reduce cost of care while improving quality of care. These techniques often include care coordination, the use of “integrated delivery systems” (systems in which patients must use specified networks of providers), utilization review (such as limits on the use of certain services or requiring prior authorization), or financial incentives to encourage members to use care efficiently. In a managed care system, individuals are enrolled in a Managed Care Organization (MCO) that is responsible for paying for and monitoring their care. MCO’s are traditionally run by insurance companies and use a variety of network models (for example, Health Maintenance Organizations (HMO’s), Preferred Provider Organizations (PPO’s), and Private Fee For Service (PFFS) plans).

Mandatory Enrollment – a model in which individuals must enroll in a plan or project in order to receive services.

Primary Care Provider (PCP) – a specified doctor/provider/clinic that an individual chooses to use as his/her central point of accessing health care. In a managed care system, members must generally consult with their primary care provider before seeking care from other healthcare providers. Managed care systems utilize primary care providers as a method of streamlining care and improving care coordination.