Medicaid Managed Care in Illinois

Make Medicare Work Coalition Webinar
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PRESENTED BY:

AGEOPTIONS

Connecting Older Adults with Community-based Resources and Options

The Area Agency on Aging of Suburban Cook County, since 1974
MMW work is supported by grants from:

- The Chicago Community Trust
- The Michael Reese Health Trust
- The Retirement Research Foundation
Who We Are: MMW Leadership

• AgeOptions
  – Area Agency on Aging (AAA) for suburban Cook County

• Health & Disability Advocates
  – Policy and advocacy organization

• Progress Center for Independent Living
  – Cross-disability, non-residential – suburban Cook County
What We Do

• Gather and create practical, accessible information and materials
• Educate Medicare consumers, service providers and policymakers
• Problem solving – individual and systemic
• Provide training and technical support for professionals and volunteers
• Advocate for consumer focused laws and policies
• Target underserved groups
What We Will Cover Today – Brief Introduction to Medicaid

- What is Medicaid?
- Medicaid Eligibility
- Categories of Medicaid Coverage
- Medicaid and LTSS
- Medicare & Medicaid
What We Will Cover Today – Medicaid Coordinated Care

Medicaid Coordinated Care

• What is Coordinated (and Managed) Care? Why is it Happening?
• Managed/Coordinated Care Programs in Illinois
• What Do All Managed/Coordinated Care Plans Have in Common?
• Enrollment Timeline
• ACE/CCE Transition – January 2016
• How Can I Tell Which Program Someone is In?

Maintaining Medicaid Coverage
What is Medicaid?

Health insurance program

Must have low income

Federal government

State government

Payer of LAST RESORT
What is Medicaid?

IL Department of Healthcare & Family Services (HFS)

IL Department of Human Services (DHS)

MEDICAID CARD
Medicaid Eligibility

• Low income - based on federal poverty levels (FPL)
  *Except for former foster children

• For most Medicaid programs, a person must be a U.S. citizen or “qualified non-citizen.”
  – Exceptions: AllKids, Moms and Babies
  – Qualified Non-Citizens = Lawful Permanent Resident (LPR) in U.S. legally for 5 years or more or a member of certain special immigrant groups (refugee or asylee, U.S. military or veteran and their dependents, individuals admitted under the Violence Against Woman Act, certain Cuban or Haitian immigrants, etc.)
Categories of Medicaid Coverage

• **ALLKIDS**
  – Children up to age 19

• **Moms & Babies**
  – pregnant women and children up to age 1

• **Family Care**
  – parents and caretakers living with children up to age 18

• **AABD/SPD Medicaid**
  – older adults and people with disabilities

• **Health Benefits for Workers with Disabilities (HBWD)**
  – people age 19-64 who have a disability and are working

• **1619 Medicaid**
  – special category for individuals who are receiving/have received SSI benefits

• **ACA Adult Medicaid**
  – Adults age 19-64

• **Medicaid for Former Foster Children**
  – age 19-25, former foster care recipient, not eligible for any other Medicaid category
Medicaid and Long Term Services and Supports (LTSS)

- LTSS = care that helps individuals perform activities of daily living (eating, cooking, bathing, getting dressed, cleaning, etc.)

- Two ways to receive LTSS:
  - Reside in a long term care (LTC) facility
  - Receive services through a Home and Community-Based (HCBS) Medicaid Waiver Program – services that allow individuals to remain in their own home or a community setting
Medicaid HCBS Waiver Programs

• 9 Illinois HCBS Waiver Programs:
  – Children and Young Adults with Developmental Disabilities – Support Waiver
  – Children and Young Adults with Developmental Disabilities – Residential Waiver
  – Children that are Technologically Dependent/Medically Fragile
  – Persons with Disabilities
  – Persons with Brain Injuries
  – Adults with Developmental Disabilities
  – Persons who are Elderly
  – Persons with HIV or AIDS
  – Supportive Living Facilities

• Fact sheets on each waiver program (who is affected, services included, etc.) available here: http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx#HCBSwaivers
Medicare & Medicaid ("Dual Eligibles")
What is Medicare?

• Federal health insurance program
• To qualify, must be:
  – Citizen or Qualified Non-Citizen
    AND
  – 65 or older
  OR
  – Under 65 with a qualifying disability
    • Lou Gehrig’s disease (ALS)
    • End Stage Renal Disease (ESRD)
    OR
    • Receiving Social Security Disability Insurance (SSDI) for at least 24 months

NOTE: Disabled adult children may also qualify for Medicare based on their parents’ work record
People with both Medicare and Medicaid – Healthcare Coverage

• Medicare pays first, Medicaid pays second

• Need to make sure providers accept BOTH Medicare and Medicaid
  – If you have Medicaid and:
    • **Original Medicare** - You may go to any doctor that accepts Medicare and Medicaid and you will pay only Medicaid co-pays for covered services.
    • **A Medicare Advantage Plan HMO** - If you go to doctors and hospitals that are in that plan’s network and accept Medicaid, you will pay low co-pays or coinsurance for covered services.
People with both Medicare & Medicaid – Drug Coverage

• Most drugs covered by Medicare Part D plan
  – If a drug is excluded from the Medicare Part D program but covered on the Medicaid formulary, Medicaid will cover
    • A drug not being on a Part D plan’s formulary does not necessarily mean it is an “excluded” drug!

• Automatically qualify for Medicare Extra Help program (federal program that helps with Part D plan drug costs) – do not need to apply

• Join a Part D plan or one will be assigned
Medicaid
Coordinated Care
Why is this Happening???

• **Public Act 96-1501, January 2011**
  – Illinois must move 50% of all Medicaid recipients into “risk-based care coordination” by 2015

• **Save Medicaid Access and Resources Together Act (SMART Act) May 2012**
  – Save $16.1 million by integrating care for most complex Medicaid beneficiaries (acute, primary, behavioral, and long-term services and supports)
Goal of Care Coordination ("Triple Aim")

- Improve health status of people and their communities
- Improve the efficiency and effectiveness of clinical care
- Reduce costs to make healthcare more affordable

(from Illinois Alliance for Health Innovation Plan)
“Coordinated Care”

Primary Care

Social Services, Housing, etc.

Specialty Care

Hospital

Long Term Services and Supports (LTSS)

Prescription Drugs

Behavioral Health
“Managed Care”

IL Department of Healthcare & Family Services (HFS)

Managed Care Organization (MCO)

Managed Care Organization (MCO)

Managed Care Organization (MCO)

Healthcare Provider

Healthcare Provider

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Healthcare Provider
Medicaid Managed and Coordinated Care in Illinois

Capitated Payment

Managed Care Organization gets paid a per member, per month flat rate (MCO takes on financial risk)
*rates impacted by client risk level

Fee For Service

Provider paid for each service individually (state government takes on the financial risk)
Illinois Medicaid Managed and Coordinated Care Programs

- Managed Care Organizations (MCO’s)
- Managed Care Community Networks (MCCN’s)
- Accountable Care Entities (ACE’s)
- Care Coordination Entities (CCE’s)
  - Serve specific populations – some for older adults and/or people with specific disabilities, some for children with complex medical needs
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Paid Capitated Rates

Care Coordination Capitated; Healthcare Services FFS
Illinois Medicaid Managed and Coordinated Care Programs

Integrated Care Program (ICP)

Medicare Medicaid Alignment Initiative (MMAI)

ACA Adult/Family Health Plans (ACA/FHP)
Illinois Medicaid Managed and Coordinated Care Programs

• Programs are currently only available in certain geographic areas of Illinois (other areas still use fee-for-service Medicaid)

• Map of Medicaid managed and coordinated care projects:
  http://www2.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf
Integrated Care Program (ICP)

- Individuals on AABD Medicaid or HBWD Medicaid who are:
  - Age 19 or older
  - On FULL Medicaid (no spenddown)
  - NOT on Medicare
  - NOT on other private insurance (that covers hospital & doctor visits)
  - NOT in the Illinois Breast and Cervical Cancer program
  - Living in one of the program’s impacted counties

- **Mandatory Program** – will be automatically enrolled into a plan if they do not choose one
  *American Indians/Alaskan Natives will not be automatically enrolled into ICP but can voluntarily enroll if they wish*

- MCO’s and MCCN’s
Medicare Medicaid Alignment Initiative (MMAI)

- Individuals with full Medicare and full AABD Medicaid benefits who are:
  - Receiving both Medicare Parts A and B
  - NOT enrolled in Medicaid with a spenddown
  - Age 21 or over
  - NOT enrolled in private insurance that provides health coverage (e.g., retiree or employer coverage)
  - NOT enrolled in a Medicaid waiver program for individuals with Developmental Disabilities
  - Living in one of the program’s impacted counties

- NOT a mandatory program. People eligible for MMAI can enroll, change plans, or opt out of the program at any time.

- MCO’s ONLY
Family Health Plans/Affordable Care Act Adult Plans (FHP/ACA)

- Individuals who are enrolled in ALLKIDS, FamilyCare, or ACA Adult Medicaid and live in one of the impacted counties
  - Some specific populations may be excluded (e.g., certain children with special needs)

- **Mandatory Program** – will be automatically enrolled into a plan if they do not choose one

- MCO’s and MCCN’s
Care Coordination Entities (CCE’s) and Accountable Care Entities (ACE’s)

• Provider-based entities who provide care coordination to members
  – in most cases, the state has still been paying for medical services on a fee-for-service basis, while these entities received a capitated care coordination fee to provide care coordination services

• Only available to certain populations in certain geographic areas
  – children with special needs, certain groups of adults with disabilities, certain groups of older adults, etc.
    – Not everyone has an option of joining a CCE/ACE

• Currently transitioning – must either achieve full capitation status on their own or partner with a managed care organization
  – Members will receive letters explaining transition and options
What do all Medicaid Health Plans Have in Common?

- Everyone eligible for a Medicaid managed care or coordinated care program will receive a letter explaining their options and will have **60 days** to choose a plan.

- All Illinois Medicaid managed care programs provide at least a 90 day **transition period** to continue seeing out of network providers when enrolled into a new plan. (MMAI provides a 180 day transition period.)
What do all Medicaid Health Plans Have in Common?

- All enrollment done through:
  
  **Illinois Client Enrollment Services**
  (877)912-8880
  TTY: (866)565-8576
  http://enrollhfs.illinois.gov/
  
- Objective, third party entity – no relationship to any of the managed care plans
- All calls are free
What do all Medicaid Health Plans Have in Common?

• They all provide **full Medicaid benefits.**
  – People in Medicaid managed care are still in the Medicaid program and have all of the rights and protections of the Medicaid program.
  – All Medicaid managed care plans must cover all of the services that FFS Medicaid covers, and they may not charge more than FFS Medicaid copayments.

• All plans provide access to **care coordinators.**

• Everyone enrolled in a managed care program must designate a **primary care physician.**
Individuals will reach their next enrollment period after being locked into their plan for 12 months – will receive another letter and go through the same process each time – Each person’s enrollment period will be different (depends on individual plan effective date)
“For Cause Switch”

• Individuals in a Medicaid managed care plan who are beyond their initial 90 day change period to switch to another plan MAY be able to change plans if there is “cause”
  – HFS does a case-by-case review

• For individuals in ICP, ACA Adult or Family Health plans
  – People in MMAI plans can switch plans or opt out of the program at any time during the year

• “For Cause” examples include:
  – PCP is not in the health plan network client is assigned to or leaves the network
  – Client develops a condition that only a sub-specialist contracted with another plan could serve

• Can request a “For Cause Switch” by contacting Client Enrollment Services
  – Request then forwarded to HFS for review
• Accountable Care Entities (ACE’s) and Care Coordination Entities (CCE’s) must transition to full capitation by January 2016

• HFS working with each ACE and CCE individually to:
  – become a Managed Care Community Network (MCCN)
  – partner with an MCO and continue to provide care coordination
  – end their services and send their members elsewhere

• Members of transitioning ACE’s/CCE’s will receive letters explaining the transition and their options.
  – If an ACE/CCE is partnering with an MCO, member will get a letter saying that and explaining their options to stay with that organization or change plans

• Still given 90 day period to switch to a different plan if desired (just like a regular enrollment period)
How Can I Tell Which Program/Plan Someone is In?

• To determine program:
  – Look at the person’s plan ID card.
    • usually have the program name listed with/under the plan name
  – Ask to see the client’s initial enrollment letter.
    • Compare to sample letters available at enrollhfs.illinois.gov (click on “Program Materials”)
    • Do they have option of opting out? (If so, MMAI)
    • What are their plan choices? Compare to list of plans available for each program (see Care Coordination map).
  – Contact Client Enrollment Services (must have client with you or have authorization).
  – Use knowledge of Medicaid categories to determine which program the client belongs in.
    • make sure DHS information is up to date!
How Can I Tell Which Program/Plan Someone is In?

• To determine plan:
  – Ask to see the ID card the person uses when they go to the doctor/pick up prescriptions.
    *This is not foolproof – client could show you an old card!
  – Call Client Enrollment Services (must have client with you or have authorization).
  – Check the Medicare Plan Finder for current coverage (MMAI only).

*In 2016, will be able to see this on new Medicaid client portal
Illinois Health Connect

Individuals who are NOT eligible for managed or coordinated care will receive information about Illinois Health Connect. Illinois Health Connect helps people with Medicaid in Illinois find and choose a “medical home” and primary care provider.

– Information about Illinois Health Connect is available here: https://www.illinoishealthconnect.com/clients/home.aspx
Maintaining Medicaid Coverage
Maintaining Medicaid Coverage

- Report changes
- Respond to redetermination notices
- If coverage cancelled but still eligible, can be reinstated within 90 days
Maintaining Medicaid Coverage

• Report changes in address, income, or household size right away
  – Call ABE call center (800)843-6154 or local DHS FCRC to report changes
  – HFS/DHS send important communications via mail – if address is not up to date, could miss important notices (e.g., redetermination notices)
Maintaining Medicaid Coverage

- Everyone with Medicaid will receive an annual “redetermination”

**Medicaid ONLY:**
Illinois Medicaid Redetermination Project (IMRP) - (855)458-4945

**Medicaid + SNAP**
Local DHS Family and Community Resource Center (FCRC)

**Medicaid + Cash Benefits**
Local DHS Family and Community Resource Center (FCRC)
Maintaining Medicaid Coverage

• Watch mail for redetermination letters; mail back right away (usually only have about 10 days to respond)
  – Can request more time if needed – call IMRP or DHS office
• If person does not respond, Medicaid will be cancelled
• If letter is lost, can request a new one
  – Call IMRP call center or DHS FCRC, depending on who sent the letter
• If cancelled, can be reinstated within 90 days
  – Contact IMRP call center or DHS FCRC, depending on who sent the letter
Medicaid Redeterminations and Coordinated Care

10 days to respond, Call for more time

Response

No Response

Redetermination Decision Made

Eligible for Different Medicaid Category

Eligible

Ineligible

Must Choose a New Managed Care Plan

Keep Coverage and Managed Care Plan

Lose Coverage and Managed Care Plan

Get Coverage Reinstated (if requested within 90 days)

Coverage Cancelled but client really is eligible...
Medicaid Managed Care Resources

- Make Medicare Work Coalition Resources on Medicaid Managed Care - Frequently Asked Questions documents for professionals, tip sheets and PowerPoint presentations for educating consumers, recorded webinars, toolkit on navigating plans, etc:

http://www.ageoptions.org/services-and-programs_MMW-MedicaidandManagedCare.html#ManagedCareToolkit
Thank you!

For more information and resources, visit our MMW webpage about Medicaid and Managed Care at:
http://www.ageoptions.org/services-and-programs_MMW-MedicaidandManagedCare.html