State Profile

Summary of Care Coordination Contract Provisions for the Illinois Integrated Care Program

This summary was prepared for a study of care coordination in managed long-term services and supports programs, conducted by Truven Health Analytics for the AARP Public Policy Institute.[1] Contracts from the following states were included in the study: AZ, CA, DE, FL, HI, IL, KS, MA, MN, NJ, NM, NY, OH, RI, TN, TX, VA, and WI. The full report and contract summaries from the 18 states are available at www.aarp.org/carecoordination. The full report includes a compilation of findings across the states.

Illinois Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	Other	Plans are required to offer care coordination to (1) all members receiving home- and community-based waiver services; (2) any member who needs it, based on the plan's risk stratification; and (3) any member who requests it.
2) Can eligible members opt out of care coordination?	Other	Home- and community-based waiver services participants must accept care coordination in order to receive waiver services. Others may opt out of care coordination.
3) Can members choose or change care coordinators?	Not addressed in contract	
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	Other	Acceptable qualifications include professional licensure as an RN, LPN, social worker, or counselor, or a bachelor's degree in related fields. Qualifications vary by waiver population served. Some waivers allow experience or certification in lieu of degrees or licenses.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
5) Are care coordinators required to have experience in long-term services and supports or disability?	No	Specific experience is not required if certain degrees or licenses are held (e.g., RN, LCSW, bachelor's degree in a specified field). In some cases, relevant experience may be substituted for degree or licensure.
6) Are care coordinators required to receive training?	Yes	A minimum of 20 hours of in-service training is required initially and annually. Topics must be specific to the home- and community-based services waiver population served.
Cultural Competency of Care Coordination		
7) Are care coordinators required to speak languages other than English when the other language is used by members?	No	Proficiency in a second language is not required.
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	Translation services are required if the member needs or requests written or oral translation. The plan must honor requests to have family members or acquaintances provide translation if the proposed translator is at least 18 years of age.
Care Coordinator Assignments, Contact Requirements, and Role		
9) Are care coordinators with certain specialties (e.g., nursing, social work, behavioral health) assigned based on the needs of members?	Yes	Plans must assign a care coordinator "who has the experience most appropriate to support the Enrollee."
10) Is in-person contact required and at what frequency?	Yes	In-person contact is required for most home- and community-based services waiver populations, and the standard varies by population, ranging from one in-person contact per month for members receiving HIV/AIDS Waiver services to one in-person contact every 90 days for members receiving Elderly or Persons with Disabilities Waiver services.
11) Is telephonic or other remote contact required?	Yes	Members who have been assessed as high risk must have contact at least every 90 days. Certain home- and community-based services waiver populations must receive more frequent contact as follows: persons with brain injury must have monthly contact; persons with HIV/AIDS must have contact three times per month. Type of contact is not specified.
12) Must initial contact with a new member be made within a specified time period?	Yes	Members with existing waiver service plans, or who are screened as high risk upon enrollment, must be contacted within 90 days of enrollment.
13) Is an assessment required at initial enrollment?	Yes	All new members stratified as high or moderate risk must have an assessment and care plan within 90 days of enrollment. This includes all members receiving waiver services. New members in nursing facilities must have an assessment and care plan within 180 days.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
14) Is reassessment required and at what frequency?	Yes	All members must be reassessed annually, or more often if significant changes occur or if the member requests reassessment. All high-risk members must be reviewed for possible reassessment every 30 days, and all moderate-risk members every 90 days.
15) Does the care coordinator authorize long-term services and supports?	Not addressed in contract	
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Yes	The plan conducts care coordination for members who self-direct.
17) Does the care coordinator play a role when members use a transition program such as Money Follows the Person to move out of institutional settings?	Yes	Contractor is responsible for managing transition of members moving from an institutional setting to a community living situation, and must provide a transitional care team for such members.
18) Does the member have a single point of contact who coordinates across specialized coordinators when needed (e.g., coordinates across long-term services and supports, behavioral, medical specialists)?	Yes	Care coordinator acts as a single point of contact.
Care Coordination Role with Family Caregivers		
19) Are family caregivers asked directly about (a) their own health and well-being; (b) level of stress and feelings of being overwhelmed; (c) need for training in assisting the member; and (d) any additional services or supports needed to better carry out their roles?	Other	Family caregivers are referenced in the care plan requirements in two ways: (1) they must be provided an opportunity for input into the plan; and (2) caregiver qualifications must be considered as part of an assessment of risks associated with the member's care.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Not addressed in contract	
21) Are family caregivers given care coordinator contact information?	Not addressed in contract	
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Plans are required to have information systems in place that integrate clinical information, assessments, and care plan.
23) Does the care coordinator have access to an electronic care coordination program?	Yes	Plans are required to have care coordination tools with this capacity.

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Element	Contract Requirement	Summary and Notes
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	Yes	The maximum caseload varies by risk level as follows: • Participants of Brain Injury Waiver or HIV/AIDS Waiver: 30 • High-risk members: 75 • Moderate-risk members: 150 • Low-risk members: 600 A weighted average is used to determine caseload for care coordinators with a mixed load.
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractors must submit several regular reports to the State, including monthly summary reports of members receiving care coordination, assessments completed and outstanding, and critical incidents. Contractors are subject to audit by the State or external quality review organization.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Other	Plans are not required specifically to measure the outcomes of care coordination, but they are required more generally to have Quality Assurance and Performance Improvement systems in place. The State has contracted with the University of Illinois Chicago to evaluate the Integrated Care Program.
27) Care coordination entity	Partners permitted	Plans may use subcontractors but are not required to do so.

Contract Reviewed: Furnishing Health Services in an Integrated Care Program by a Managed Care Organization *(2010-24-005-KA4).*

1 Saucier, P. and B. Burwell. 2015. *Care Coordination in Managed Long-Term Services and Supports*. AARP Public Policy Institute.

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