Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
June 16, 2011

401 S. Clinton Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Members Present
Kelly Carter, IPHCA
Kathy Chan, IMCHC
Ann Clancy, CCOHF
William Gorski, MD, Swedish American Health System ***via telephone***
Art Jones, MD, LCHC
Vince Keenan, IAFP
Margaret Kirkegaard, MD, IHC, AHS
Diana Knaebe, HBHC ***via telephone***
Jerry Kruse, MD, MSHP, SIU SOM
Mike O'Donnell, East Central Illinois Area Agency on Aging, Inc.
Edward Pont, MD, Illinois Chapter AAP
Indru Punwani, DDS, MSD, Department of Pediatric Dentistry ***via telephone***
Janet Stover, IARF

HFS Staff
Julie Hamos
Theresa Eagleson
Jacqui Ellinger
Jim Parker
Joe Holler
Gina Swehla
Michelle Maher
Robyn Nardone
Mike Jones
Ann Lattig
James Monk

Members Absent
None

Interested Parties
Mary Ellen Baker, MedImmune
Geri Clark, DSCC
Ann Clancy, Heartland Alliance
Mary Driscoll, IDPH
Gary Fitzgerald, Harmony Health Plan
Pat Gallagher, ISMS
Barbara Hay, FHN
George Hovanec, Consultant
Andrea Kovach, Shriver Center
Gordana Krkic, IAFP
Keith Kudla, FHN
Michael Lafond, Abbott
Dawn Lease, J & J
Michael McCabe, United Health Care
Sarah Megan, Prairie State Legal Services
Diane Montañez, Alivio Medical Center
Randy Nash, HMA
John Nicolay, Maximus
Pam Northrup, La Rabida Children's Hospital
James O'Dowd, Prairie State Legal Services
John Peller, AIDS FDN of Chicago
Steve Perlin IHA
Eli Pick PMC Consulting
Matt Powers, HMA
Olivia Roanhorse, Ounce of Prevention Fund
Ken Ryan, ISMS
Heather Scalia, Meridian Health Plan
Doug Schenkelberg, Heartland Alliance
Robin Scott, CDPH
Maria Shabanova, Maximus
Jo Ann Spoor, IHA
Susan Stewart, Abbott Diabetes Care

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I. Call to Order

The Care Coordination Subcommittee was called to order at 10:15 a.m. Dr. Pont offered to chair the meeting and there was no objection by committee members.

II. Introductions

Participants in Chicago and Springfield introduced themselves. Dr. Pont provided opening remarks. He commended the department for enlisting a distinguished group to participate as members of this subcommittee. A handout showing a list of the members was provided with the meeting agenda and posted online at. http://www.hfs.illinois.gov/mac/cc/members.html

III. Review of Charge

A handout of the draft subcommittee charge was provided (Attachment 1). Dr. Pont reviewed the charge which states, in part, as follows: "The Care Coordination Subcommittee is established to advise the Medicaid Advisory Committee concerning strategies for expanding and enhancing Healthcare and Family Services' medical home healthcare delivery system as part of the effort to enroll 50% of its clients in coordinated care by January 1, 2015 …. This subcommittee will: study ways to enhance the current Primary Care Case Management Program, Illinois Health Connect, to comply with the requirements of Illinois' Medicaid reform law [P.A. 96-1501]". No changes were recommended to the charge.

IV. Review of Care Coordination Principles

Two handouts on Care Coordination principles were provided to participants. These are the Principles of Care Coordination - *First Draft, 3/18/11* (attachment 2) developed by HFS; and Subcommittee on PCCM improvement, (attachment 3) developed by Dr. Pont. These documents were the basis for the discussion on care coordination.

Members engaged in a thoughtful discussion of some of the primary elements to consider in a care coordination model. Summary of the discussion points follows.

Care Coordination Complexity and Specialty Referral

- Consideration should be given to modifying the care coordination fee structure to reflect more complex care coordination.
- Care coordination should include communication with staff like the dietitians and WIC.
- The care coordination system should identify special needs patients and also identify medical homes that can address those needs.
- It is difficult to determine who is getting care coordination as the computer edits never turned on for referral to specialists.
- HFS' MEDI system allows for sharing information in a HIPAA compliant way and approximately 80 percent of providers have MEDI access.
- Use evidence based practices to develop referrals.
- Agencies on Aging are working on evidence based care models to coordinate care.
- The department should look at the Internet Referral information System (IRIS) developed by the Cook County Safety Net Partnership to reduce inappropriate referrals and processing time.
- Management payments should continue across the board with adjustments for age and gender.
- The department should reimburse for communication between specialists and PCPs.
- Electronic or virtual specialty provider consultation needs to be explored.
- If the department moves to electronic consultation, it must pay for a review of the specialty referrals by a specialist to make sure the referrals are appropriate.

Care Coordination as a Function

- The National Quality Forum defines 5 domains for care coordination: 1) healthcare home that has an enduring relationship; 2) information about patient shared with team; 3) proactive plan of

care and follow-up; 4) information systems in place to share, and; 5) transition or "hand-off" function.

- The payment mechanism under the PP-ACA looks at health outcomes. Need to operationalize outcomes to incorporate into current system. Swedish America hospital works with Crusader clinic. The clinic is hiring a case manager to identify patients with congestive heart failure and to link the patient with the specialist and case manager.
- Need to look at functions that the medical home does that are plausible on a statewide basis.
- In long term care (LTC) there is a shift from care encounters to care coordination. LTC is moving to a more global approach to manage episodes of care.
- Use appointment reminders to help ensure that appointments are kept. IHC has a system for appointment reminders that includes telephone patch in the doctor's office to help make an appointment.
- With multiple providers seeing a patient, coordination is important to ensure proper services and medication management provided in both the inpatient and outpatient settings.

Looking at Shared Risk

- Sharing risk is another way of saying payment system reform.
- With risk, one has to look at managed care and the desire to pick healthy persons to enroll. Focus should be on reimbursing for taking risk in coordinating care for persons with medical needs.
- Consider that in order to receive management payment, the provider must demonstrate care coordination.
- At some point, must enforce care standards.
- Care should be stratified to compensate for taking higher risk.
- Illinois needs to design a system that will bring providers in.
- Across the state, many providers are ready for "pay-for-performance". Would need a transition phase to incentivize the process.
- There is a need to move providers to assume risk so that they have some "skin in the game".
- Consider incentivizing process with blended fees in areas of fee-for-service, care coordination and pay-for performance (P4P).
- Set up fee-for-service reimbursement. The P4P under IHC is small, perhaps 1% to 2% of a provider's revenue. When payment for taking risk is 15%, it is likely to drive behavior.
- Over 18 years in Great Britain the system phased in with 35% of payment being tied to performance.
- In Canada, payment breaks out as 50% fee-for-service, 40% care coordination and 10% P4P.
- Need to move to "downside" risk. The proportion of compensation that should be downside risk would be 10 to 15%.
- MCOs have 100% risk. About 80% of their providers have downside risk of 10 to 15%.
- There also needs to be tools for providers to manage risk. It may be useful to look at the Illinois Comprehensive Health insurance Program (ICHIP) as far as incorporating risk.
- Health outcomes for a provider are dependent on who is served. Must look at outcome expectations for the homeless and substance abusers.
- Consider multiple players like BlueCross Blue Shield as a model for assessing and paying for risk.

Thinking About Care Coordination via an Entity and Other Thoughts

- HFS is looking for input on who would be in a position to provide care coordination or be the "integrator" entity.
- A possible model is for the PCPs to be coordinators of care. Fees would be paid by age and gender. The entire population could be broken down geographically, such as by county. The expectation would be for PCPs to identify high risk patients and specialty care needs.

- The business and risk considerations would be hardest for providers to adjust to.
- Must consider size of panels. Some panels as few as 50 persons. The provider can't afford case management for each patient.
- Part of case management is helping patients to understand treatment regimens.
- It is important for the state to provide data for an entity to determine strategies for care coordination. A key to medication management is visiting the home.
- Dentists work only with fee for service, so there is a need to learn more about care coordination models and how the dental community will fit in. Healthy children can have great dental needs.
- There is a population in need of care coordination with personal, intellectual and behavioral health challenges. How to address these individuals needs to be included in the discussion of integrated care.
- How to be home health neighbors to verify care for the general population. The average person on disability has 7 prescriptions. There is interest in creating better linkages to manage care for this population.

V. Next Steps

James Parker, Deputy Administrator, Division of Medical Programs, referred to a questionnaire, The Coordinated Care Program Key Policy Issues June 2011, sent to about 2000 persons and posted by the department on the internet to solicit comments and facilitate establishing minimum standards for care coordination. The posting is at http://hfs.illinois.gov/cc/. Comments are due by close of business, July 1, 2011.

The department plans to review the comments and to meet in late summer or early fall to post the minimum requirements a coordinated care program would need to meet. It would be good for the subcommittee to meet at least one time this summer to be ready for the fall review.

VI. Next Meeting Date

Subcommittee members discussed a possible next meeting date. It was agreed to meet next on July 19th from 10 a.m. to Noon.

VII. Adjournment

The meeting was adjourned at 12:20 p.m.

Charge for the MAC's Care Coordination Subcommittee

June — 2011

The Care Coordination Subcommittee is established to advise the Medicaid Advisory Committee concerning strategies for expanding and enhancing Healthcare and Family Services' medical home healthcare delivery system as part of the effort to enroll 50% of its clients in coordinated care by January 1, 2015, as required by P.A. 96-1501. This subcommittee will:

1. study ways to enhance the current Primary Care Case Management Program, Illinois Health Connect, to comply with the requirements of Illinois' Medicaid reform law [P.A. 96-1501];

2. study various patient focused service delivery models, including integrated care and accountable care organizations;

3. study the use of both financial and nonfinancial incentives to improve the quality of healthcare outcomes and reduce health disparities between low- and high-income enrollees through comprehensive care;

4. study the use of evidence-based practices and electronic medical records to facilitate communication between PCPs and other health care providers; and

5. based on such studies, make recommendations to the Medicaid Advisory Committee.

PRINCIPLES OF CARE COORDINATION

First Draft, 3/18/11

Person-centered. Care coordination organizes care around the diverse needs of the Medicaid enrollee in order to promote health and independence. The care coordination team conducts an assessment, including, as appropriate, the enrollee's physical, mental, psychosocial, and cognitive functioning, medication use, and family caregiver capacity to assist with care. The assessment is conducted in accordance with the enrollee's risks, needs, goals and preferences.

Comprehensive services, linked by an integrator. A range of services is offered to meet the majority of the individual's needs, including a primary care physician, referrals from the primary care physician, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, and when appropriate, rehabilitation and long-term care services. Care is delivered in a culturally and linguistically appropriate manner, incorporating evidence-based practices as appropriate and available. Where necessary, the care coordination program assigns an integrator to the enrollee, with responsibility for providing or arranging the majority of care needed to ensure the continuity of care across multiple settings and providers.

Assessment of quality, performance and health outcomes. Standards of quality care and outcomes are measured to assess the performance of the care coordination program. Where possible, electronic health records are used to help care coordinators collect data and manage treatments and services.

Risk-based payment systems. Payments to care coordination programs are made either on a capitated basis in which a fixed monthly per enrollee is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements. The program or program integrator may be paid for care coordination services without being responsible for direct payment for medical services provided; however, payments include a component of risk, based on overall cost of care or on quality and outcome measures. Payments to providers are

adequate to provide continued access to quality healthcare for Medicaid enrollees, with movement toward financial accountability systems where payments reflect the complexity of the enrollee's condition, the quality of care rendered and outcomes for the enrollee.

Population-based. Care coordination programs serve an identified population that is enrolled. The program or program integrator does not exclude any member of the population for which it is responsible. Enrollees may be required to enroll in a care coordination program, with enrollee protections to assure quality and access.

Reduced bureaucratic barriers. State agencies work to abide by principles of coordination, by streamlining their policies, procedures and other requirements to promote the efficient use of care coordination across programs, agencies and budgets. Providers and vendors are offered incentives to minimize administrative barriers in their organizations.

Principles of Care Coordination Comprehensive services linked by an "integrator." Payments reflect patient complexity	**Current PCCM** PCP office serves as care coordinator	**Proposed change to PCCM** Diminution or elimination of the care coordination fee for patients who do not receive comprehensive care	**Operational changes proposed** VFC participation; 24 hour coverage; extended hours	Enhanced care coordination fee for medically complex patients **and/or medical home certification**
Initial intake assessment	No formal policy	Encourage providers to perform comprehensive intake assessment	Modifier on new code for enhanced reimbursement	MN example, AAP Bright Futures
Provide care across multiple settings and providers	No formal policy	Enhance communication between PCP and other providers of health care	Utilization of the IHC portal to facilitate communication between the PCP and specialist	**ICARE;** "Who's my PCP" function to enhance communication between ER and PCP; **centralize reminder function at IHC**
Electronic Health records & quality assessment	Periodic physician reports with statewide comparisons	Encourage utilization of electronic health records	Utilize "meaningful use" criteria, consider augmenting federal incentives	
Risk-based payment systems	P4P and well care bonuses based on HEDIS metrics	Regional or systemwide risk pool linked to improved nonurgent ER and hospital utilization		