Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
July 19, 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
Kathy Kelly, M.D., for William Gorski, Swedish American Health System ***via telephone***
Art Jones, M.D., LCHC
Vince Keenan, IAFP
Margaret Kirkegaard, M.D., IHC, AHS
Jerry Kruse, M.D., M.S.H.P., SIU SOM ***via telephone***
Diane Slezak, Age Options for Mike O'Donnell, ECLAAA, Inc.
Edward Pont, M.D., Illinois Chapter American Academy of Pediatrics
Indru Punwani, D.D.S., M.S.D., Department of Pediatric Dentistry ***via telephone***
Chris Burnett for Janet Stover, IARF

HFS Staff
Julie Hamos
Mike Koetting
Joe Holler
Gina Swehla
Michelle Maher
Susan Greene
Laura Ray
Mike Jones
Amy Wallace
Lora McCurdy
Gina Swehla
Robyn Nardone
Michelle Beasley
Ann Lattig
James Monk

Members Absent
Diana Knaebe, HBHC

Interested Parties
Jessica Bott, ISDS
Carrie Chapman, Legal Assistance Foundation
Geri Clark, DSCC
Sue Clark, Moline Healthcare
Mike Colif, ICARE, Wisconsin
Jill Fraggos, Children's Memorial Hospital
Barbara Hay, FHN
George Hovanec, Consultant
Vince Keenan, IAFP
Kiernan Keating, Takeda
Keith Kudla, FHN
Michael Lafond, Abbott
Azmina Lakhani, SGA
Tim O'Brien, Sinai Health System
Steve Perlin, IHA
Matt Werner, Consultant
Roberta Rakove, Sinai Health System
Olivia Roanhorse, Ounce of Prevention Fund
Camille Rodriguez, IARF
Dee Ann Ryan, ACMHAI
Ken Ryan, ISMS
Robin Scott, CDPH
Lauren Seemeyer, ICAAP
Maria Shabanova, Maximus
Jo Ann Spoor, IHA
Debbi Smithe, CRSA
Ed Stellon, Heartland Alliance
Ann Stock, Ounce of Prevention Fund
Brenda Wolf, LaRabida hospital

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I. Call to Order

The Care Coordination Subcommittee was called to order by Dr. Pont at 10:15 a.m.

II. Introductions

Participants in Chicago, Springfield, and those attending by telephone, introduced themselves.

III. Review of June 16, 2011 meeting minutes

Dr. Pont asked about a statement by Dr. Jones on page 2, paragraph 4. "It is difficult to determine who is getting care coordination as the computer edits never turned on for referral to specialists." Dr. Pont clarified that Dr. Jones would not make turning on of the specialist edit a requirement to be considered a care coordination entity. Dr. Jones replied that as soon as we have adequate access to specialists, we should turn on the edit. Dr. Pont agreed. Following the discussion, the minutes were approved, with no changes.

IV. Update on comments received to Coordinated Care Program – Key Policy Issues

Director Hamos advised the group that 76 responses to the *Coordinated Care Program Key Policy Issues June 2011* questionnaire were received. She then introduced Susan Greene, who is working with the department to launch the Innovation Project.

Ms. Greene is reviewing the questionnaire comments along with Michelle Beasley, a presidential management fellow on loan from the federal CMS. The comments are available online at: http://hfs.illinois.gov/cc/comments. She thanked those who took the time to respond.

Ms. Greene did not attempt to summarize the comments, but instead talked about how the department intends to use the comments submitted. She indicated that there is a range of readiness to move into risk-based or shared-savings arrangements. Consensus has started to evolve around some questions. There's a variety of opinions on most issues that can be summarized as how coordinated care should be approached, paid for, organized and implemented. HFS intends to bring all the suggestions into internal deliberations about the range of issues that need to be discussed. The director hopes to pull stakeholders together and have conversations around the issues identified to see if we can move in a direction of agreement.

Participants were given a handout, *Care Coordination and Timeline – July 15, 2011* (See Attachment 1). Director Hamos described the process that will take place over the next 18 months in developing the Innovations Project. The department envisions that coordinated care could be organized by entities other than traditional HMOs, thereby giving these entities the opportunity to pull together provider networks to offer care coordination. The department doesn't know what capacity exists in the community to do this or what segment of the population would be served or how many of the Medicaid population would be served using this approach. In Phase 1of the project, Ms. Greene will assist in creating a solicitation for care coordination entities by the end of 2011. HFS then wants to give 4 to 5 months for the entities to submit proposals and hopes to announce the awards next summer.

Over the next year, the department will also be engaged in hospital rate reform. HFS expects that the rate reforms will be taken up in next spring's legislative session, at the same time the Phase 1 care coordination plans are being developed. The hospital rate reform is necessary in order to achieve the 50% enrollment in care coordination required under the State's Medicaid Reform law.

In Phase 2, starting next fiscal year, the department will move to increase care coordination on a larger scale, by assessing what clients are being served and who is serving them, with the goal of opening it up to traditional managed care companies, as well as entities trying to develop new models of care coordination. The director asked for feedback on the proposal.

A discussion on the Innovations Project timeline and hospital rate reform followed. Highlights of that discussion are summarized below.

- The director advised that the proposal evaluation process is still to be worked out and the MAC would be advised as the process is developed.
- It was suggested, that the more guidelines HFS can provide to groups that wish to apply as a coordinated care entity, the more likely they will be ready to respond with a timely proposal.
- Interested parties will want to know what state plan waivers or amendments HFS might be applying for before developing proposals, especially for special populations. The department is currently looking at the full range of federal opportunities relating to care coordination, rebalancing the long term care system, some of which would require a state plan amendment.
- It was recommended that care management proposals of a special population must be independent of an established model in Phase 1.
- HFS wants to give a range of parameters of what it is looking for that will pass the legal department and provide an opportunity to come forward with creative ideas and structure for populations that providers are interested in. The goal is to work on activities already engaged in, rather than dictating a model.
- It was reiterated that the legislation was very clear that HFS must have risk based payment arrangements. Some have recommended not making the arrangements full risk. There should be a public conversation about the range of risk based arrangements that are used or thought about.
- The department should provide medical billing data to potential bidders in a way that is not so expensive for them to access and analyze.
- HFS and bidders should look at opportunities through CMS and CMMI for funding demonstration projects that allow money for planning and coordination.
- Some Chicago based foundations have expressed interest in helping with healthcare reform.
- The hospital rate reform is critical because currently about 42% of the payments received by hospitals is in the form of lump sum, static, supplemental payments; meaning the payments are not directly related to a service rendered. In moving to risk-based care coordination models, continuing to pay supplemental payments to hospitals when a portion of such payment was necessarily factored into a capitation contract for the care coordination entity is duplicative. In order to comply with the Medicaid reform law, hospital rate reform must occur.

V. Discussion of Enhancements to Illinois Health Connect Program

Dr. Pont stated that the subcommittee's charge is to look at modifications for the current Primary Care Case Management program, Illinois Health Connect (IHC), so it satisfies the requirements for care coordination in the law. He introduced Dr. Margaret Kirkegaard, of Automated Health Systems, who serves as the Medical Director for IHC.

Dr. Kirkegaard provided participants with a handout, *Illinois Health Connect: Ensuring a Medical Home* (See Attachment 2). She gave an overview of the existing program, identifying core functions as creating a network of physicians that provide a medical home environment and matching them to newly eligible clients into a "best fit" medical home. She explained voluntary and mandatory enrollment and indicated that 80% of the enrollments are voluntary. Other functions performed by IHC include:

- Providing well-child appointment reminders during phone contacts or by timely reminder letters; with appointments for these visits usually scheduled in less than 7 days.

- Contacting adults on an annual basis to recommend a preventive care visit. IHC is investigating using auto-calling to allow appointment scheduling within 48 hours of the call and expanding reminders for other services like PAP smears and mammograms.
- Participated in a variety of specialty projects utilizing the call center for outreach. During low call periods, IHC can do special projects; a recent example being working with CDPH in contacting African American women with reminders to obtain a mammogram. During the flu season the call center was handling up to 80,000 calls per month.

The following summarizes the discussion on IHC:

It was noted that sometimes providers find there is no correlation between the patient reminder and whether the service has been provided. This causes more confusion for the patient. Dr. Kirkegaard explained that for patient reminders, IHC depends almost exclusively on HFS claims data, but also gets immunization data from Cornerstone and ICARE, and IDPH data on lead screening. When the data is received depends on the particular provider and how quickly they submit claims. It takes about 7-10 days between when HFS adjudicates the bill and when IHC receives the data. IHC would welcome opportunities to enhance this by getting data directly from providers, such as hospitals or clinics. However, a key question is how much work can be put into data exchange before it becomes redundant to the health information exchange work currently underway.

Dr. Kirkegaard was asked how long an enrollee is with a PCP. She explained that right now people have a lot of freedom of choice in changing their PCP; which can affect the collection of data for preventive services. Experience has shown that only 2,000 out of the 1.6 million people enrolled with IHC would be considered as “frequent” changers. When enrollees change four times a year, IHC flags the file to discuss continuity of care the next time the enrollee calls to switch PCPs. In order to ensure continuity of care, there must be a balance between locking a person into a PCP choice and allowing choice.

The 20% of patients that are auto-assigned are not necessarily persons with disabilities. Although a structured analysis hasn’t been done, the idea that an auto assigned patient is disabled or homeless is not necessarily true. IHC did look at ED patients and found they were no more likely to be auto-assigned than other enrollees. At times, auto-assigned enrollees don’t contact IHC because their auto assignment is to a doctor they are already seeing, so they just accept the assignment.

The IHC specialist database is limited to about 2,300 providers. If a specialty care provider registers in the IHC database, additional information about provider characteristics is obtained and can be discussed with the caller. Most specialty providers elect not to register with IHC, but prefer to maintain their collegial referral relations.

Dr. Kirkegaard indicated that with the discontinuance of the disease management program, Your Healthcare Plus, IHC anticipates continuing some of these functions for the DM program. McKesson provided some management to patients for frequent ED use and IHC will continue having that flag on the panel roster. Call center staff will suggest to high ED users that they call their PCP. The goal is to get IHC patients connected back to their PCP.

Claims history data is available to any Medicaid provider with access to the MEDI system, which is a free service provided by HFS. At last look, about 2,000 providers were accessing claims history per month. The MEDI system is the gateway to the IHC system. Providers can look up any current Medicaid patient by using the patient’s recipient number, SSN and name, or date of birth. This function is used by emergency rooms, care coordinators and hospital case managers. IHC would like to promote “outside the medical home” as an opportunity to enhance care coordination simply by providing data. IHC does track who signs into MEDI for quality control reasons.

There are about 1.8 million persons assigned to Illinois Health Connect and 3/4 of these are children. The remainder consists of persons in FamilyCare or what was called AABD and is now called seniors and persons with disabilities (SPD). It was not possible to say how many enrollees are SPD.

At the time the PCP referral system was implemented about 8 months ago, the call center was receiving as many as 80,000 calls per month; which was IHC's highest call volume. The nature of the calls was people who needed to change their PCP, didn't know where their PCP was, asking about access to specialty care, general questions about benefits and questions about how Medicaid works.

IHC has not collected data related to a strategy to refer high users of ED back to their PCP. It wasn't a contractual focus. But, with the disease management program ending, IHC is just beginning to look at expansion of our project internally to determine what gaps IHC may need to address.

In the future, IHC would like to serve to support HFS' coordinated care Innovations Project. There is a role for a centralized function for client assignment and for a centralized call center to use for some of these data functions in supporting the medical home. HFS will determine the final structure. IHC is not sure how much additional risk it would take on. IHC is not accredited as a health plan and doesn't serve as a financial intermediary for HFS. There are some risk elements in our current contract. There are financial withholds for clinical quality improvement. This is an area that could be expanded.

Director Hamos stated that the IHC contract is up next summer. In the Medicaid Reform law, the legislature was very firm about adding language on the PCCM program not qualifying as a care coordination entity. The subcommittee is being asked if the current PCCM structure doesn't qualify, then what does.

Vince Keenan stated that the IHC and the DM programs solidified the primary care provider community into responding in a very positive manner towards the Medicaid program. This is seen both in terms of clinical data showing more responsiveness to the preventive health services and in the low number of changes by patients once assigned to a PCP. It is important as we talk about how to shape the Innovation Project to have a consistent message along the way.

Discussion on Subcommittee on PCCM improvement document

Dr. Pont asked participants to review the document, *Subcommittee on PCCM improvement* (See Attachment 3) that shows changes in bold based on comments received at the subcommittee's last meeting. He suggested that people may want to continue to discuss and reconvene to recommend changes to the PCCM, or if comfortable with this document and think it reflects discussions, we can vote on this and bring it to the MAC in September. He asked if the document adequately reflects what we have talked about, and is it sufficient to present to the MAC. There was discussion on who is the final decision maker for what constitutes enough risk to meet the legislative requirement? And, if HFS makes a recommendation on this, will the legislature go along?

Director Hamos stated that there is no easy answer. HFS, working with the legislature, would make the final decision. The department has worked with the legislature to think in a new way about risk based management and not full capitated risk. There is a sense that coordinated care is a solution to our budget problems; so, as the budget gets worse there will be more pressure to solve it with this approach.

Dr. Jones thought the changes laid out in the document were positive, but didn't believe they went far enough to bring about change in provider behavior for the savings the legislature is looking for. He recommended that if PCCM is not included in the 50% requirement, HFS should run a parallel analysis and make that decision. He would encourage making the changes outlined, but cautioned that there is not enough change to satisfy the 50% requirement.

Dr. Pont stated that if the monthly fee is reduced or withheld when there isn't evidence of care coordination, it would put a significant amount of money at risk for primary care providers. He believed it would be a reduction of a minimum of 5% and closer to 10% of the PCP's payment.

Dr. Jones stated that in his opinion the $2-$3 monthly payment does not influence provider behavior. He thought phasing in the augmentation of pay for performance is a positive change, but would recommend comparing outcomes for PCCM with outcomes for persons enrolled in coordinated care. He is aware that a comparison of the quality measures is already being done. He was not so sure that we have a fair comparison of financial performance and would let some of the MCOs comment.

Director Hamos believed that maybe a better question for the group to consider is what really helps to change provider behavior and what behavior are we trying to change.

Kelly Carter commented that we need a more realistic way to define comprehensive care before the subcommittee can make a suggestion to the MAC. Dr. Kruse had made some very good points about what comprehensive care means and how can we measure it through the department's claims system, as it is different for different populations.

Dr. Kirkegaard commented it could be as simple as setting the standard that if a patient is not seen in their medical home, the care coordination fee isn't activated until seen. It is a measurable, obtainable bar that would propel provider behavior into outreach.

Ms. Carter was concerned that telephone and address information passed to the PCP from department records was frequently inaccurate and it wouldn't be good to hold PCPs accountable for not being able to reach a patient or to bring them in if service is not needed.

Dr. Kirkegaard indicated that perhaps if a patient doesn't live near their medical home they should be reassigned. IHC has had several scenarios where the patient identifies a certain address, but lives 100 miles from the medical home. From experience, the number of times you call a patient is proportional to your opportunity for reaching them. To meet the 80% voluntary enrollment rate we may need to call a patient 20 times. If a practice had a risk-based payment, they may allocate the resources or partner with someone like IHC who can make the contact more efficiently. Some states have a broader definition of children's special health care needs and care management is allocated much more intensively to those kids. This might be something to look at here.

Dr. Pont stated the grid shows an enhanced care coordination payment for medially complex patients. We could take from one pot and give these care coordination dollars where most needed on these medically complex kids. Where a practice has achieved a certain level of "medical hominess," their care coordination fee would go up a certain amount. That was in Dr. Kruse's document (See Attachment 4). The changes proposed here would be as good in terms of care coordination as the majority of provider care coordination out there.

Ms. Greene noted that under the risk based payment systems on the grid it shows "regional or system wide risk pool linked to improved non-urgent emergency department (ED) and hospital utilization. Given the difficulty sometime in finding patients, it puts some of the responsibility on those that find the patients in their ED; which is often the "front door" to hospitalization. She asked if this was suggesting that the pool might include changed process behaviors in the ED.

Dr. Pont answered that one example in Dr. Kruse's document is giving that responsibility to a county health department or organization that coordinates with the PCCM to go to EDs and say you're having problems with patient X; let's see if we can get resources to that patient to keep them out of the ED. Have some financial incentive that could be distributed to the PCP for keeping the patient out of the ED.

Dr. Kirkegaard has proposed to HFS that a bonus payment would be split between the PCP and the ED for patients that made a follow-up PCP visit within a set time after the ED visit. There is an incentive for both parties to cooperate.

Dr. Pont asked for comments on using the MEDI portal to coordinate specialist care better.

Dr. Kirkegaard stated that the functionality currently exists. IHC was instructed to build a referral mechanism statewide for all Medicaid providers, but currently it only shows IHC PCPs. The MEDI system is populated with all the specialists who are Medicaid providers in the state of Illinois but the data is hidden. It could be turned on and function as that mechanism for the PCP to authorize a patient to be seen and the specialist would be able to use the database to verify that authorization was given.

There is also a functionality to put in clinical data for the specialist to see and gives the opportunity to print a form for the patient saying that I am referring you to "X" cardiologist. The piece of paper is not the referral, as the referral is electronic, but it serves as an appointment reminder for the patient to have with the name and address for the specialist.

Ms. Greene stated there was discussion after PCCM was implemented about requiring authorization to specialty care. It is not that easy for a patient to self-refer to specialty care and there may be insufficient access statewide to guarantee access. That led to a decision to not turn on that system.

Dr. Pont stated that a fair number of specialists do ask for a referral outside the system. An enhancement allowing the PCP to speak with a specialist and be able to communicate electronically would be welcome. If specialists could, through that portal, consult without even seeing the patient; and there would be a payment; it would really set PCCM apart.

Ms. Chan asked for clarification on when recommendations on changes to the PCCM program accepted by the department would go into effect. Ms. Greene stated that the department will be issuing an RFP for the program next year and that recommendations from the MAC would be timely to include in the next contract.

Director Hamos stated that the group has framed some new questions. Dr. Jones framed some in how you change provider behavior. The director would ask "where is the skin in the game." A lot of people in the PCCM still end up not just in the ED, but as hospital admissions; some of which may be preventable. And, they still end up going from provider to provider. That is what care coordination in essence is about. It may not be the children you see in your practice, but we have a lot more complex cases in the Medicaid program. If we think of PCCM as the hub, the question is how do we organize the spokes around the hub? That is not necessarily reflected in the grid. What pulls it together? Dr. Jones has said the $2 pm/pm really isn't it. So what is? That is a discussion that we still need to have more reflection on. We need to organize that conversation a little differently and perhaps bring other people to the table.

Dr. Pont responded that we are trying to make PCCM more risk-based and suggest more enhancements so that more care is coordinated; such as specialty care, or the "who's my PCP" function that is mentioned in the document, and such as an enhanced intake assessment. The question before us is will those changes, if implemented, be sufficient to get us over the 50% hurdle.

Dr. Kirkegaard stated that IHC welcomes these suggestions so that 6 months from now we can actually be better informed on what works. IHC also welcomes other suggestions because even if we can't implement them we can look at what might be necessary to implement them or try them on a pilot level.

Director Hamos shared that HFS would be open to hearing some ideas for pilots. IHC could test some of these new concepts even in the bounds of a contract and HFS would figure out some small way to enhance the contract to test these theories and concepts. The Director suggested finding time on the

next agenda for a presentation by some of the other players like BlueCross/Blue Shield or a HMO to see what they are doing and then compare that to what we have already heard.

VI. Open to Committee

Mr. Keenan stated that where Dr. Kruse is heading with recommendations for a blended care coordination payment represents some pretty exciting ways to look at things. Dr. Kruse brings a lot of experience at the national level and knowledge of how it is being done in some other areas. Mr. Keenan highly recommends taking a look at his report.

It was decided that additional discussion was needed prior to sending a recommendation to the MAC.

VII. Next Steps

The next meeting was scheduled for September 13, 2011 at 10 a.m.

VIII. Adjournment

The meeting was adjourned at 12:00 p.m.

Pat Quinn, Governor
Julie Hamos, Director

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CARE COORDINATION PLAN AND TIMELINE
July 15, 2011

Current Status:

The Department of Healthcare and Family Services (HFS) currently manages 4 programs of capitated managed care for the Medicaid population: Three of these programs are voluntary for clients who are children and their parents; about 200,000 have enrolled.

The remaining program is mandatory for about 40,000 clients who are Seniors and Persons with Disabilities ("SPD", formerly "AABD"), who are in the process of being enrolled in the new Integrated Care Program in the suburbs and collar counties. As of July 12, there have been 17,169 enrollments into the Integrated Care Program, with 8,851 members (52%) joining Aetna Better Health and 8,318 (48%) joining IlliniCare Health Plan.

Illinois Law:

The new Medicaid reform law states that Illinois must enroll 50% of the Medicaid population in "care coordination" by January 1, 2015. This means at least 1.5 million of our Medicaid clients – children, parents, seniors and disabled persons – will be assigned to an integrated healthcare delivery system replacing the current fee-for-service fragmented system. Under the Affordable Care Act, as of January 1, 2014, about 700,000 Illinoisans currently without health insurance will be eligible for Medicaid for the first time; it is expected that all of these new applicants will be enrolled with care coordination entities.

Care coordination is defined broadly to include both traditional managed care companies as well as new alternative models of care organized and managed by hospitals, physician groups, Federally Qualified Health Centers (FQHC) or social service organizations. Care coordination entities must provide or arrange for a majority of care around the patient's needs, including a medical home with a primary care physician, referrals to specialists, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, and when appropriate, rehabilitation and long-term care services. The law also specifically states that care coordination must include risk-based payment arrangements related to health care outcomes, the use of evidence-based practices and the use of electronic medical records.

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Phase I FY2012 Plan:

In May, HFS issued a white paper on Policy Issues in Care Coordination, listing a set of complex policy issues that must be resolved in order to develop and implement care coordination in Illinois. To date, we have received about 75 responses, indicating tremendous community interest in testing new coordinated service delivery systems. We will hold public hearings or "conversations" to focus on areas of complexity or on issues where there is no consensus.

HFS will develop the Innovations Project as Phase I in order to test community interest and capacity to provide alternative models of delivering care (i.e. not through traditional HMOs) -- serving children/families, special populations, and seniors/persons with disabilities. HFS and partnering state agencies will develop the process of soliciting proposals from a wide range of community providers.

The Innovations Project solicitation process is expected to be announced by the end of year, 2011, with a timeline that gives 4-5 months to potential care coordination entities to submit proposals. During this period, they will likely need to analyze Medicaid data for the population to be served, to organize networks and partners, and to fully develop their systems of care. The state will also need time for required federal approvals of possible new waivers and state plan amendments. Awards should be announced by the summer of 2012.

Concurrent with the development of the Innovations Project, HFS will seek to reform the hospital rate reimbursement system. There are numerous deficiencies in the current rate system; this fact is widely acknowledged by the hospital community as well. However, the most significant problem for the state with the current hospital reimbursement system is that claims-based payments, those tied directly to services, account for just 58% of all payments to hospitals. Static, lump sum, supplemental payments, unrelated to current utilization, comprise 42% of hospital reimbursements. This makes the current system incompatible with the law requiring 50% of clients to be enrolled in care coordination. The collaborative effort between the state and the hospital community to reform the rate structure, currently underway, will achieve a smoother transition to the 50% goal and create the foundation for value-based reimbursement based on quality care.

Phase II FY2013 Plan:

Phase II is envisioned to increase care coordination on a much larger scale. At this time, the degree of community provider response to the Innovations Project is unknown, as is the percentage of Medicaid clients that will be served in alternative models of care. Phase II will add to the population served in care coordination, and likely will include traditional managed care companies as well as other models of care. A solicitation process for Phase II services will begin in summer, 2012. However, prior to implementing large-scale risk and/or managed care/care coordination, it is essential that hospital rate reform be accomplished through legislation.

For more information, please contact Theresa Eagleson, Medical Programs Administrator, 217-782-2570.

Illinois Health Connect: Ensuring a Medical Home

July, 2011

Margaret Kirkegaard, MD, MPH, IHC Medical Director, mkirkegaard@automated-health.com

Illinois Health Connect Overview

- Illinois Health Connect has created a primary care provider (PCP) network of over 5,700 primary care physicians, clinics and other providers who have agreed to create a medical home for their clients. Currently the IHC PCP network has a capacity for 5.4 million clients and approximately 1.8 million clients are enrolled.
- IHC call center staff enrolls newly eligible clients into "best fit" medical home. Currently about 80% of clients are contacted during the 60-day enrollment period and actively select a medical home. (The majority of the 20% of auto-assigned clients do not have a valid phone number for outreach.)
- During both inbound and outbound calls, IHC call center staff reminds all households with children if they are due for a well-child visit. This amounts to 24,000 reminders per month. If clients require assistance, a 3-way call will be made with the medical home. If the appointment is more than 7 days in advance, an appointment reminder will be sent via mail. IHC is investigating using automated calling for the appointment reminder so that reminders can be made for appointments with a shorter time frame. IHC is investigating expanding these conjunctive reminders for other health services such as pap and mammography.
- IHC sends all patients ages 2 to 21 years a reminder letter for well-child visit according to the periodicity schedule established by HFS. Children under age 2 years receive a reminder letter at 6 and 18 months.
- In the past, IHC called households to initiate a well-child appointment starting at 60 days prior to the child's birthday. IHC made up to 17,000 calls per week but found that families were largely unwilling to make an appointment at the time of the call. Only 4% of calls resulted in an appointment. IHC has now moved to a strategy of calling families who are past due for a well-child appointment focusing currently on preschool-aged children.
- IHC contacts all adults on an annual basis to recommend an adult preventive care visit. Most adults are contacted via automated calling and those who are not contacted via calling receive a letter. (average 22,000 calls per month and 7,000 letters)
- IHC has participated in a variety of special projects utilizing the call center to outreach to clients such as the CDPH project to reduce breast cancer screening disparities in Austin and Roseland neighborhoods where IHC has called 6,000 women as a reminder for mammography. For women who are interested, IHC facilitates a transfer to the PCP to schedule a women's health checkup or to CDPH mammography centers.
- IHC assists with access to specialty care for IHC clients. Clients who contact IHC for assistance in accessing specialty care are first referred back to their medical home to ensure care coordination. If the client has indicated that the problem has been under evaluation with their PCP, then IHC assists the client and provides a list of potential specialists. IHC has registered 2350 specialists who have indicated a willingness to accept IHC clients. Additionally, IHC tracks specialty requests

by specialty type and geographic region to inform recruitment needs. IHC also accesses the Medicaid Provider Database to determine Medicaid eligible specialists and other agencies such as Early Intervention. In a previous pilot project, IHC assisted clients in actually making specialty appointments. This was not well-received. Clients preferred to get a list of available providers and determine which one was most appropriate and make their own appointment. IHC receives approximately 10,000 calls per month from clients to assist for specialty care. IHC also cooperates with Cook County Health and Hospital Systems by providing PCPs access to the IRIS system (an internet based referral scheduling program). IHC is interested in collaborating in providing systems to enhance telehealth (e.g. PCPs could access through the IHC Provider Portal) and e-consultations if payment is established.

- Through academic detailing by Provider Service Representatives and Quality Assurance Nurses, IHC visits approximately 350 PCPs each week and delivers important information regarding the administration of the program, general updates from HFS, use of the quality tools and site-specific clinical information. IHC also uses the IHC communication infrastructure for webinars, blast faxes and provider newsletters to keep providers engaged and informed.
- IHC provides numerous quality tools to participating providers including:
    - Panel Roster: Lists current IHC patients linked to the PCP, as well as most recent demographic data. Also includes clinical indicators for well child visits, developmental screening, pap tests, mammography, and vision testing. Includes a "flag" for patients who meet the criteria for diabetes based on claims data and a "frequent ED" flag for clients who have used the ED 6 or more times in the past 12 months.
    - Provider Profiles: Semi-annual report of approximately 20 measures based on HEDIS metrics such as immunization rates.
    - Claims History: an electronic database of at least 2 years of claims data (including pharmacy) and 6 years of immunization data available through the MEDI system to any Medicaid provider for any current Medicaid clients including patients who are excluded from IHC.
    - IHC is working to create a monthly report for each provider posted on the Provider Portal that would identify children at ages 17 to 24 months who are not up to date on their immunizations.
- IHC has created a Bonus Payment Program for High Performance targeting 6 common clinical measures for quality improvement. In 2009, over $2.8 million, and in 2010, $3.2 million was distributed to nearly 4500 providers for care provided in the previous year that exceeded the quality standards. In 2010, approximately $3.7 million will be distributed.
- IHC collaborates with a wide-variety of other quality improvement initiatives either by providing data to projects (e.g. IHC was able to identify PCPs with children ages 0 to 3 years *old to target* for ICAAP Bright Smiles fluoride varnish program) or by academic detailing and disseminating information such as : The Autism Program, IDPH's Chronic Disease Self-Management Program, ICARE, CHIPRA, etc.

Subcommittee on PCCM improvement

Principles of Care Coordination	Current PCCM	Proposed change to PCCM	Operational changes proposed	
Comprehensive services linked by an "integrator." Payments reflect patient complexity	PCP office serves as care coordinator	Diminution ~~or elimination~~ of the care coordination fee for patients who do not receive comprehensive care	VFC participation; 24 hour coverage; extended hours, **dual eligibles**	Enhanced cc payment for medically complex patients and/or medical home certification, **phase in augmentation of P4P**
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 **MEDI** portal to facilitate communication between the PCP and specialist, **e-consult payments (IRIS at Cook Cty)**	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		

MAC Care Coordination Subcommittee

Recommendation for a Blended Care Coordination Payment
Across-the-Board care coordination payments plus
Care Coordination Payments for High risk, High Vulnerability Patients

Jerry Kruse, MD, MSPH

Researchers at the Johns Hopkins Bloomberg School of Public Health have shown that care coordination in Patient Centered Medical Homes reduces healthcare costs and improves healthcare outcomes[1,2] . More recently researchers from the Center for Excellence in Primary Care Institute at the University of California San Francisco, the IBM Global Healthcare Transformation Initiative, and the Patient-Centered Primary Care Collaborative have corroborated this information by studying care coordination systems and Patient Centered Medical Homes in the United States.[3]

Medicaid systems in the United States, including those in North Carolina, Illinois, and Wisconsin, have shown improved healthcare outcomes and lower costs when there are Across-the-Board payments for care coordination that are combined with care coordination payments for high cost, high vulnerability patients. The provincial universal healthcare systems in Canada, particularly in Ontario, demonstrate that Across-the-Board payments that are stratified by five year age intervals and by gender are most effective in improving outcomes and lower costs.[4] As representative of the Association of Departments of Family Medicine (the organization of all the chairs of Family Medicines in medical schools in the United States) to the Departments of Family Medicine in the medical schools in Canada, I have been able to observe this system firsthand..

For the past four years, I have been a member of COGME, a federal advisory committee to the Secretary of Health and Human Services, to the Senate Health, Education, Labor, and Pension Committee, and to the House Energy and Commerce Subcommittee on Health. COGME recently produced its 20th Report, which reviewed all of the above literature, and found the two types of care coordination payments to be effective in improving the healthcare system and improving health for the population.[5]

Over the past few years, Illinois Medicaid has provided across the board care coordination payments through the Illinois Health Connect Program, and has arranged for a private enterprise, McKesson, to perform care coordination of high risk, high vulnerability patients. It is my belief, based on all of this data, that a system which blends the two types of

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[1] Starfield B, Shi L, Macinko D: Contributions of Primary Care to Health and Health Systems, *Milbank Quarterly.* 83(3), 2005

[2] Starfield B, Shi L: The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics,* 2004;113:1493-99

[3] Grumbach K, Grundy P: Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States, November 16, 2010. http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf

[4] Family Health Teams, Advancing Family Healthcare, Guide to Physician Compensation, September 2009, version 3.0.

[5] COGME 20th Report. http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf

payments for care coordination will be the most effective in improving the health of the citizens of Illinois and lowering healthcare costs. Following is a short explanation of the two types of payments.

1. Across-the-Board Care Coordination Payments to Primary Care Practices in Patient Centered Medical Homes

Patient Centered Medical Homes (PCMHs) are primary care practices that are usual sources of comprehensive, longitudinal care and exhibit the four central functions of primary care: 1) first contact access, 2) patient focused care over time, 3) comprehensive care, and 4) coordinated, integrated care. Recently high functioning data management systems have been shown to assist these practices in achieving the four essential functions of primary care. PCMHs may be identified either by NCQA certification, or achieving a proper range of evaluation and management codes set by CMS standards.

Per-member per-month care coordination payments that are paid for all patients in the practice (across-the-board) are most effective when stratified by five year age intervals and gender. An example is shown below in Table 1. In the Canadian experience, 12 to 14 year old males are the least costly group to the healthcare system. Actuarial analysis has been utilized, particularly in the province of Ontario, to determine the relative cost of other age groups. In Table 1, a base payment of $4 per member per month for 12 to 14 year old males has been used as an example, and the per-member per-month payments for other age groups has been computed using multipliers based on the actuarial analysis in Ontario. $4 per-member pe- month for 12 to 14 year old males was chosen because experience in other states, such as Wisconsin, has shown that average payments of $6 per member per month is an adequate incentive to develop sophisticated care coordination systems.

Across the board care coordination payments are utilized to perform many of the functions that are defined in NCQA certification. A function of major importance is the registry function, in which all patients eligible for various types of healthcare screening are listed, and in which patients with various diseases are monitored to determine the effectiveness of the practice in achieving practice benchmarks and improving healthcare indicators. Across-the-Board care coordination payments are also effective in providing pre-visit preparation, meaningful use of electronic health records, visit summaries, medication reconciliations, tracking the laboratory tests and consultations, and assurance of coordination of between the care in the primary care office and outside agencies, such as consulting specialists physicians, hospitals, nursing homes, mental health organizations, and community service agencies. Each care coordination payment can also be used to help directly provide mental health services under the roof of the Patient Centered Medical Home. This has been done for some time in Hamilton, Ontario and has now been implemented at the SIU Quincy Family Practice Center in Quincy, Illinois. Thus, the main function of Across-the-Board care coordination payments is the provision of a financial incentive for members of the practice to organize data and reach all patients who are assigned to the practice. It is understood that there will be variable success in this endeavor, but the data clearly shows the effectiveness of Across-the-Board care coordination payments in improving health outcomes and lowering costs for the system.

Table 1
Example:
Across-the-Board Care Coordination Payments for Primary Care Practices in Patient Centered Medical Homes

	Payment ($ per month)	
Age (years)	Male	Female
0-4	9.47	8.94
5-11	4.91	4.85
12-14	4.00	4.12
15-19	4.29	6.78
20-24	4.30	8.83
25-29	4.67	10.01
30-34	5.31	10.16
35-39	5.75	9.41
40-44	5.79	8.91
45-49	6.61	9.70
50-54	7.06	9.87
55-59	7.80	9.72
60-64	8.94	9.86
65-69	10.44	10.91
70-74	12.58	12.72
75-79	14.79	14.71
80-84	18.13	18.05
85+	23.49	24.05

Explanation: This table begins with a $4.00 per member per month payment for 12 to 14 year old males, the least costly group to the health care system. Payments for other age groups are derived from multipliers determined by actuarial analysis by age and gender in Ontario. (Guide to Physician Compensation, September, 2009, Version 3.0)

2. Care Coordination for High Risk, High Vulnerability Patients

Several states and nations have shown the importance of making an effort to identify high risk, high vulnerability patients from a population to receive intensely coordinated community-based care. There is evidence, best described by the community care of North Carolina program[6], but also demonstrated by states such as Illinois, that a population-based assessment of

[6] Community Care of North Carolina http://www.communitycarenc.org/

high risk, high vulnerability patients is the method most likely to effectively improve outcomes and lower healthcare costs. In North Carolina, community steering committees receive a per-person per-month payment for every Medicaid patient in the area served by the steering committee. Most often, the steering committees are the county public health departments. The total payment to the health department is used to identify high risk, high vulnerability patients and to hire care coordinators to provide intensive community-based services to improve access to care, quality of care and to be a patient advocate. In North Carolina, the care coordinators hired by the public health departments have offices in the primary care practices, to better increase integration between various community agencies and the primary care practice. Care coordinators facilitate transitions of care for the patient such as hospital to home, hospital to nursing home, home to nursing home, primary care physician to consulting specialty physician, etc. The care coordinators also have a direct link to pharmacy management services, which has been highly effective. In North Carolina, the per-person per-month payments for the Medicaid population in the area of the steering committee approximately equals the per-member per-month care coordination payments to the primary care practices for Across-the-Board care coordination.

3. Summary

I believe that the MAC Care Coordination Subcommittee should recommend a system of care coordination payments for both Across-the-Board care coordination at the practice level, and for care coordination for high risk, high vulnerability patients at the population level. Study must be done to determine the absolute amount of payments, but the payments should be of sufficient magnitude to incent the primary care practices and the public health departments to develop services that will optimally improve healthcare outcomes and lower costs. I have no doubt that closer collaboration between public health departments and primary care practice Patient Centered Medical Homes is an absolute necessity for the most effective, efficient and equitable healthcare system for the state of Illinois.

PCMH-PPC Proposed Content and Scoring

Standard 1: Access and Communication	Pts
A. **Has written standards for patient access and patient communication****	4
B. **Uses data to show it meets its standards for patient access and communication****	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. **Uses paper or electronic-based charting tools to organize clinical information****	6
E. **Uses data to identify important diagnoses and conditions in practice****	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. **Adopts and implements evidence-based guidelines for three conditions ****	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. **Assesses language preference and other communication barriers**	2
B. **Actively supports patient self-management****	4
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. **Tracks tests and identifies abnormal results systematically****	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. **Tracks referrals using paper-based or electronic system****	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	3
B. Survey of patients' care experience	3
C. **Reports performance across the practice or by physician ****	3
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**** Priority Elements**

Physician Practice Connections and Patient Centered Medical Home