Medicaid Advisory Committee's
Care Coordination Subcommittee Member Listing
June 2011

Name	Organization
Carter, Kelly	Chief Operating Officer Illinois Primary Health Care Association
Chan, Kathy	Associate Director Illinois Maternal and Child Health Coalition
Clancy, Ann, R.D.H.	Project Director Chicago Community Oral Health Forum
Gorski, William, M.D.	President – Chief Executive Officer SwedishAmerican Health System
Jones, Art, M.D.	Founding Physician Lawndale Christian Health Center
Keenan, Vince	Executive Vice President Illinois Academy of Family Physicians
Kirkegaard, Margaret, M.D.	Medical Director, Illinois Health Connect Automated Health Systems
Knaebe, Diana	President – Chief Executive Officer Heritage Behavioral Health Center
Kruse, Jerry, M.D., M.S.H.P.	Chairman, Depart. of Family & Community Medicine SIU School of Medicine
O'Donnell, Mike	Executive Director East Central Illinois Area Agency on Aging, Inc.
Pont, Edward, M.D.	Illinois Chapter of the American Academy of Pediatrics
Punwani, Indru, D.D.S., M.S.D.	Professor & Head, Department of Pediatric Dentistry College of Dentistry, University of Illinois
Stover, Janet	Executive Director Illinois Association of Rehab. Facilities

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.

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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.