Illinois Department of Healthcare and Family Services and Cook County Health and Hospitals System

Cook County Health and Hospitals System's Care Coordination Enhancements and Bridge to ACA

Medicaid 1115 Waiver

Proposal

January 6, 2012

TABLE OF CONTENTS

I. Executive Summary 3

II. Background: CCHHS' Central Role in the Safety Net 4

III. Eligibility 8

IV. Provider Network 11

V. Proposed Care Management Plan 14

VI. Stakeholder Input 20

VII. Budget Neutrality and Cost Reconciliation 20

VIII. Measurement and Quality 27

IX. Preliminary List of Waivers and Flexibilities Sought Under the Demonstration 29

X. Conclusion 29

Appendices 31

I. EXECUTIVE SUMMARY

The Governor's Office and the Illinois Department of Healthcare and Family Services (HFS), in collaboration with the Cook County Board and the Cook County Health and Hospital System (CCHHS) to request an 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) effective July of 2012, to cover the current uninsured population that will become eligible for Medicaid in 2014. While this waiver application is written with a focus on Cook County, the waiver could provide for any willing county in Illinois to participate if HFS and CMS standards are met. This waiver will allow CCHHS to decrease its uninsured population and provide funds to improve the quality, coordination, and cost-effectiveness of the care it provides. The waiver will jump-start the enrollment process for the sub-group of "newly eligible" patients. Finally, it will help prepare a critical part of the safety net for the substantial changes that will take place starting in 2014.

While a traditional health care coverage expansion before January 2014 would be extremely challenging given the financial conditions in Illinois as in other states, the Illinois Health Care Reform Implementation Council's January 2011 report singled out an exception and endorsed consideration of a waiver to expand Medicaid under the right circumstances. An 1115 waiver for CCHHS is a great opportunity for all levels of governance to work together and make a profound impact on safety net patients in Cook County.

Key components of the proposed waiver:

- **Population:** An estimated 250,000 eligible adults in Cook County with income levels at or below 133 percent of the federal poverty level (FPL) could gain coverage. Other counties/regions could have the opportunity to opt-in, and the income eligibility limits could be adjusted to reflect available funding.

- **Benefits:** Benchmark coverage will be comprehensive but more limited than traditional Medicaid. Core benefits for adults will include inpatient and outpatient hospital services, physician services, prescription drugs, mental health services, laboratory and x-ray services, emergency services, family planning services, and emergency and non-emergency transportation services.

- **Network**: Services under the waiver will be delivered in a network regionally-developed by CCHHS using community partners to meet the needs of the uninsured. Except for emergency services, covered services for the waiver population will be limited to those provided within the CCHHS network, and HFS and CCHHS will work together to make this limitation clear to the covered population and providers. Care coordinators will reinforce in-network requirements with patients and will follow up with patients who seek care outside the network.

- **Medicaid Provisions:** While the Affordable Care Act (ACA) allows states to expand Medicaid before 2014 in this manner, this plan will require a waiver of the Medicaid "freedom of choice," "statewideness," and "comparability of services" requirements.

II. BACKGROUND: CCHHS' CENTRAL ROLE IN THE SAFETY NET

Cook County is the second most populous county in the nation, with more than 5 million residents or 40 percent of those living in Illinois. The County has a low health status ranking overall, and areas such as the south portion of Cook County score especially poorly on a variety of population health indicators that could be improved by more consistent access to the right health services at the right time. Areas with the lowest health rankings currently have the least access to care. More consistent and stabilized access to health care that become possible with Medicaid coverage will provide life-changing services to patients and could bring essential resources to a system that is struggling to serve the safety net population.

As the flagship of the health care safety net for metropolitan Chicago, CCHHS has a commitment and an obligation to provide health care for uninsured and underinsured persons; the demographic characteristics of this population have evolved over the 150 years that Cook County has been providing health and medical care. Over time, socioeconomic conditions and their effects, such as rapid economic development and in-migrations of new populations, have shaped the healthcare challenges that CCCHHS facilities and programs confront.

Healthcare outcomes data from the University of Wisconsin/Robert Wood Johnson Foundation help to illustrate how poorly the residents of Cook County rate relative to national and state-level health benchmarks. The bleak statistics are often associated with unhealthy behaviors, such as smoking and excessive drinking, and preventable diseases, such as sexually transmitted infections, that can be better addressed with a different approach to health care. Avoidable complications from undetected and undertreated chronic diseases lead to otherwise unnecessary disabilities and medical costs. The situation has not been solved simply by having an adequate number of primary care providers. The uninsured need access to well-functioning medical homes that focus on prevention, early detection of illness and coordinated comprehensive management of chronic diseases. It is wise to provide that access now, through an 1115 waiver, for this high risk population rather than postponing this to 2014, when further deterioration of health status will consume even more resources.

Figure I. County Health Rankings: 2011 Estimates1

	Cook County	Error Margin	National Benchmark*	Illinois	Rank (of 102 IL Counties)
Mortality					53
Premature death	7,533	7,452- 7,614	5,564	6,859	
Morbidity					85
Poor or fair health	18%	17-19%	10%	16%	
Poor physical health days	3.4	3.2-3.5	2.6	3.3	
Poor mental health days	3.3	3.2-3.5	2.3	3.2	

[1] County Health Rankings, 2011: Cook, Illinois. Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. http://www.countyhealthrankings.org/illinois/cook. Accessed 9/9/11.

	Cook County	Error Margin	National Benchmark*	Illinois	Rank (of 102 IL Counties)
Health Behaviors					7
Adult smoking	21%	20-22%	15%	21%	
Adult obesity	25%	24-27%	25%	26%	
Excessive drinking	20%	19-21%	8%	19%	
Motor vehicle crash death rate	9	9-10	12	12	
Sexually transmitted infections	647		83	460	
Clinical Care					61
Uninsured adults	20%	19-21%	13%	17%	
Primary care providers	620:1		631:1	778:1	
Preventable hospital stays	83	82-83	52	83	
Diabetic screening	75%	74-77%	89%	80%	
Mammography screening	58%	57-60%	74%	63%	
Physical Environment					101
Access to healthy foods	92%		92%	53%	
Access to recreational facilities	9		17	10	

CCHHS HISTORICAL STRENGTHS WILL HELP WITH ACA EXPANSION

CCHHS is one of the largest and most comprehensive public health and hospital systems in the country. It provides a full range of hospital inpatient, trauma/emergency care services, full spectrum care and primary care at the main Stroger Hospital campus. Adult inpatient care, primary care and a more limited spectrum of specialty services are also provided at the Provident Hospital campus. The third regional campus, Oak Forest, now provides primary care and limited specialty care. These services are accessed by patients not only already consistently served by CCHHS, but also patients with no primary care provider or those who have private primary care providers outside of the CCHHS system. The CCHHS System also includes the following: community primary care clinics in the most vulnerable neighborhoods in the city and suburbs; public health services for suburban Cook County; and a unique, comprehensive, multidisciplinary facility caring for patients with HIV/AIDS and other infectious diseases. CCHHS is the predominant provider of care for medically indigent persons in Cook County, and its viability has a significant impact on both the patients who rely on it and other hospitals and clinics that will be overwhelmed if it failed or did not exist. It will continue to be the major provider of care for those who remain medically uninsured well after 2014.

By utilizing its historical strengths in providing integrated acute, emergency, specialty and primary care, CCHHS can lead the effort to provide the current uninsured population in Cook County with a medical home and medical insurance coverage prior to the 2014 ACA expansion. This waiver will help CCHHS and the Cook County region begin the process of restructuring its patient care system prior to January 2014, strengthening CCHHS's stability within the Chicago delivery area while also helping the currently

uninsured population access the new opportunities available to them. The expansion of coverage under healthcare reform will substantially reduce the percentage of the population that is uninsured in Cook County. It will also affect the lives and CCHHS's work with the remaining, post-ACA, uninsured. It is estimated by the Metro Chicago Information Center (MCIC) that about 250,000 people with incomes under 133 percent of poverty will be newly eligible for Medicaid, excluding the undocumented[2]. There are several reasons the 1115 waiver will be a good fit for CMS, HFS, and CCHHS as it will:

1. Initiate the daunting task of enrolling the uninsured population who will be eligible for coverage in 2014, using this experience to guide the subsequent enrollment process for the rest of the state;
2. Stabilize the health status of this currently uninsured population to improve its health status now, preventing permanent disabilities and reducing future costs;
3. Prepare for the HFS policy direction of placing the "newly eligible" population into risk-bearing, care coordination in 2014; the waiver provides time for this population to learn how to access care within the context and restraints of a managed care system;
4. Help transition CCHHS and many of its safety net partners, and/or community partners, into becoming high value providers that are able to function under capitation/bundled payments and provide patient centered medical homes; "community partners" will be sought-after partners who can share their expertise with CCHHS and fee-for-service-dependent FQHCs to help them redesign their models of care and prepare them to compete effectively for the newly insured;
5. Help HFS and CMS gain significant information from the waiver to help estimate the cost of caring for this newly insured population and use this waiver experience to project future costs to care for this population and to construct capitation models. HFS and CMS will also be able to gain an earlier understanding of some of the implications of new coverage on the safety net delivery system;
6. Help CCHHS to work towards being a more responsive, communicative and cost-effective care coordination partner; non-CCHHS primary care physicians will direct their patients to high value providers of specialty care, diagnostics and inpatient care; this is the opportunity for CCHHS to hone its abilities and demonstrate it to other safety net providers; and
7. Help CCHHS to build a system of care and partnership for those who remain uninsured post ACA; it can focus its 1115 partnership efforts on providers willing to expand their commitment to care for this population as well.

ACA EXPANSION PRESENTS OPPORTUNITY

The expansion of Medicaid, scheduled for 2014 in the ACA, will provide health insurance coverage for many of the County's uninsured. The County is interested in acting now to expand earlier coverage to a population for whom ACA puts a major emphasis on improving access and quality of care.

Over the years, CCHHS has consistently assumed the responsibility for serving patients who simply have not been served elsewhere. In Figure II, audited data provided by Illinois hospitals to HFS demonstrate

[2] Metro Chicago Information Center – August 2010 estimates

that CCHHS's Stroger Hospital provides more than twice the amount of care to the uninsured relative to the next nine largest hospital providers to the uninsured combined.

Figure II. 2009 OBRA Report Comparison for Illinois [3]

#	Hospital Provider	Est. Cost of Care to Uninsured
1	***Stroger Hospital (main CCHHS hospital)***	***$ 419 million***
2	OSF Saint Francis Medical Center	$ 32 million
3	Mount Sinai Hospital	$ 30 million
4	Advocate Christ Medical Center	$ 28 million
5	Advocate Illinois Masonic Med. Ctr.	$ 21 million
6	Ingalls Memorial Hospital	$ 19 million
7	University of Chicago Hospitals	$ 18 million
8	Mercy Hospital & Medical Center	$ 12 million
9	Norwegian-American Hospital	$ 12 million
10	St. Francis Hospital & Health Ctr.	$ 12 million

While CCHHS has consistently served patients who could not receive care elsewhere, the CCHHS system currently faces many delivery and financing challenges, including:

- An increase in the number of uninsured and underinsured due to the economic downturn;
- Persistent, significant unmet healthcare needs that lead to sicker patients when they enter the health system;
- Large disparities in access to healthcare services for racial/ethnic, financial, and geographic reasons;
- Challenges facing Cook County government related to the current difficult economic conditions; and
- Potential threats to Medicaid revenue with disproportionate share hospital payment reductions.

ACA will provide resources to care for many of the current uninsured and underinsured, but many of the Cook County residents will remain ineligible and uninsured. CCHHS will continue to shoulder a dominant share of that burden. Additionally, special funding mechanisms for uncompensated care (e.g. disproportionate share funding) are scheduled to be reduced. This 1115 waiver represents a financial opportunity that will enable CCHHS to make delivery system changes to improve effectiveness and efficiency of the system.

CCHHS possesses a unique opportunity to help its community and state in transitioning to national health reform. Driven by HFS leadership and a 2011 state law, HFS is in the process of shifting away from a fee-for-service payment reimbursement structure statewide towards a more integrated health care delivery system that includes a greater emphasis upon using bundled payments subject to achievement

[3] HFS 2009 OBRA reports; CCHHS 2009 Medicare cost reports

of certain health care quality measures. These efforts place emphasis on care coordination, evidence-based medical practices and the use of electronic medical records. Illinois is currently contracting with managed care organizations (MCOs) in a mandatory risk-based project in suburban Cook County and the surrounding counties for the Aid to the Aged Blind and Disabled (AABD) population as well as a voluntary risk-based managed care program for the AFDC-related population. HFS submitted a Letter of Intent to CMS to participate in its Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees program, many of whom are now cared for within the CCHHS system. These, and other care coordination efforts, will expand into Chicago with significant impact on CCHHS. A January 2011 state Medicaid reform law requires that at least 50% of the Medicaid population be in risk-bearing, coordinated care by 2015. HFS and CCHHS see the 1115 waiver as an important **part** of their strategy to achieve compliance with this state law. It will begin the process of linking newly Medicaid eligibles into medical homes and will allow CCHHS time to make necessary adjustments.

III. ELIGIBILITY

Illinois has traditionally maintained generous coverage thresholds in Medicaid, yet hundreds of thousands of Cook County residents remain uninsured. In preparation for the expansion authorized under ACA, HFS and CCHHS will offer a regional opportunity to expand eligibility before 2014 using an approach similar to the Medicaid Coverage Expansion/Health Care Coverage Initiative authorized under California's Section 1115 Medicaid waiver. Although Cook County will likely be the only Illinois county interested in early ACA coverage, this waiver request could permit an "opt-in" for other eligible and interested counties or regions in Illinois. Given the short period of time between the writing of this waiver application, and January of 2014, this waiver application assumes that CCHHS is the only Illinois county moving forward at this point in time.

ACA PROVISIONS

Section 2001(a)(1) of the Affordable Care Act requires states to cover a new population of low income persons beginning on January 1, 2014. This new eligibility group excludes individuals eligible for Medicaid, CHIP or Medicare coverage but includes all others, without an asset test, who:

- Have income at or below 133% FPL[4],
- 19 years of age and older and under 65 years of age, and
- Are either US citizens or legal non-citizens in the US for at least five years.

Throughout this document, references to "the waiver population" will be made and are intended to directly comport with the ACA population above. Another ACA provision, 1902(k)(2) gives states the option to expand eligibility for those newly eligible under Section 2001(a)(1) before January 1, 2014. States are prohibited from covering higher income individuals before lower income populations and from covering parents when their children are not eligible for Medicaid, a Medicaid waiver or other health insurance coverage.

[4] Note – may work with appropriate income disregard policy to approximate the income standard allowed under ACA

COVERED POPULATION

Illinois proposes to exercise its option to expand Medicaid eligibility to include the new optional eligibility group of persons with income under 133% FPL. This expansion will be limited to Cook County residents, unless other counties choose to opt into the program and will include adults with income 0-133% FPL who are not otherwise financially eligible for Medicaid. An estimated 250,000 residents of Cook County are expected to gain eligibility with this early expansion.

BENEFITS

The waiver will provide for benchmark coverage and will be comprehensive but more limited than the current Illinois Medicaid benefits. Core benefits for adults will include inpatient and outpatient hospital services, physician services, prescription drugs, mental health services, laboratory and x-ray services, emergency services, family planning services, and transportation services.

Relative to the Illinois Medicaid benefit package, some services will be excluded. These services are detailed in the budget neutrality section of this document. Also, service limitations will be applied to certain services including some mental health services. The service limitations will be no more restrictive than those limitations reflected in other recent 1115 waiver approvals for newly eligible populations (e.g. California). These service limitations will be detailed in the terms of conditions of the waiver.

Waiver's Proposed Covered Benefits
INPATIENT HOSPITAL
DRUGS
PHYSICIAN
OUTPATIENT HOSP.
CLINIC
LAB AND X-RAY
CASE MGMT.
TRANSPORTATION
NURSE PRACTITIONER
OTHER PRACTITIONER
OTHER SERVICES

OUTREACH

Illinois' on-line Medicaid, CHIP and state coverage application will be the centerpiece of the application process for waiver eligibility. This application is used by applicants applying for the state's All Kids, FamilyCare and Moms & Babies health programs. With the assistance of trained application agents, outreach workers or by themselves, applicants answer application questions on-line. They then print and sign the signature page and mail it and all required verification documents to the appropriate state eligibility workers.

CCHHS will work to promote the new coverage category and assist individuals in applying for coverage. CCHHS will work to assure that complete applications are submitted through the on-line application system. CCHHS will engage additional resources to work with individuals to use the most efficient application mechanisms that HFS and CCHHS have available.

ELIGIBILITY DETERMINATION

As permitted in the CMS State Medicaid Director (SMD) letter regarding the Medicaid expansion dated April 9, 2010, Illinois will initially use income counting methods other than the Modified Adjusted Gross Income (MAGI) based method that the state will use in 2014. The income method will be consistent with

current methods used in Medicaid and will meet the SMD letter requirement that income methods be "reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests of the beneficiary".

Using information submitted by means of the on-line application, eligibility workers will determine eligibility and enroll individuals in waiver coverage after the following determinations are made:

- Applicant has income at or below 133% FPL;
- Applicant is 19 years of age and older and under 65 years of age;
- Applicant is a Cook County resident;
- Applicant is a US Citizen or a legal immigrant in the US for more than five years;
- Applicant is not otherwise eligible for Medicaid;
    - For those with income under 100% FPL and assets under the ABD asset level, is not blind and has not been adjudicated as disabled;
    - Is not pregnant; and
    - Is not a parent living with his or her children.

Those found eligible for the waiver will be sent an approval notice and information indicating that non-emergency coverage is limited to services provided by the CCHHS provider network. Those found eligible will also be informed that their enrollment in the waiver will not preclude the waiver enrollee from applying for Medicaid under a different class of coverage and that a different class of coverage may be beneficial to the enrollee.

Eligibility cards will be mailed to newly approved waiver enrollees in the same manner used for other Illinois Medicaid eligibility categories. Providers and recipients will have access to a system that will indicate that non-emergency services are limited to those provided by the CCHHS network. HFS will maintain coverage for waiver enrolled individuals by making address changes, etc. when reported by enrollees and by performing annual coverage renewals. Waiver applicants and enrollees will have all the same hearings and appeals rights as other Medicaid eligibility groups do.

HFS and CCHHS may request early permission to utilize the Presumptive Eligibility option as articulated in Section 2202 of the Affordable Care Act (ACA). This option permits any hospital acting as participant in the State's plan to elect to be a qualified entity for the purpose of determining, on the basis of preliminary information collected, whether any individual is eligible for either medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period.

MEDICAL HOME SELECTION

As with the state's Primary Care Case Management program, Illinois Health Connect (IHC), individuals found eligible for waiver coverage will work with the HFS's Enrollment Broker to select a medical home within the CCHHS network. As described in the Care Management Plan section of this waiver application, patients will have the opportunity to choose a CCHHS Patient Centered Medical Home (PCMH). This home will be a team that will provide ongoing care for a defined panel of patients and will

be accountable for the health of that patient population. Individuals who fail to choose a PCMH team will be assigned to one in the same way other Medicaid enrollees are assigned to IHC primary care physicians but with input from CCHHS and the home will be within the CCHHS network. Requests to change PCMH teams will be subject to the similar requirements as with IHC.

IV. PROVIDER NETWORK

In order to improve care for the previously uninsured population, it will be important to provide for appropriate access to services. HFS and CCHHS are committed to ensuring that under the waiver, an appropriate range of preventive, primary and specialty services are offered that are adequate for the anticipated number of waiver enrollees. Although it will be allowable for CCHHS to require that enrollees in the waiver expansion group receive services from a closed network built on the CCHHS delivery system, CCHHS will supplement the available providers with subcontracted "community partners". CCHHS has extensive, existing collaborative relationships, through its specialty care referral system and the Medical Home Network (MHN) (both of which will be discussed in this paper.) In choosing partners, CCHHS will base network expansions on the geographic location of providers and waiver enrollees, considering distance, travel time, the means of transportation ordinarily used by potential waiver enrollees, and whether the locations provide physical access for enrollees with disabilities. Partnerships with the community partners will also be based upon clinical capacity issues, availability of data, and affordability.

The following concepts and principles will be priorities in moving towards of improving access for patients within the CCHHS network:

- Urgent care clinics open at 3 regional campuses 365 days per year,
- Urgent care access that promotes appropriate patient behavior,
- Availability of early morning and evening hours in primary care, and
- After-hours access to primary care physicians.

The purpose of the waiver is to expand coverage immediately to at least some of the State's uninsured and better prepare the delivery system for the large influx of newly-insured individuals in 2014. Services under the waiver will feature the CCHHS system with some added support from key community partners. Community partners will be hospitals, clinics, and other providers from the Cook County region which complement the CCHHS provider infrastructure. As indicated, the community partner complement will be geographic, capacity-related, or service related. Many of the community partners already have existing relationships with CCHHS. CCHHS has an ambulatory system providing approximately 350,000 primary care visits, 300,000 specialty visits, and over 300,000 diagnostic visits annually. In addition, CCHHS hospitals provide over 200,000 annual ER visits. CCHHS has a culture of teamwork and cooperation in its comprehensive system between the disciplines and providers. CCHHS has over 80 percent of its providers operating with an Electronic Medical Record (EMR) of some sort. Patient charts, prescription writing, and provider documentation (e.g. progress notes) are done electronically or committed to electronic format (electronically written, scanned or dictated into the EHR).

SPECIALTY AND DIAGNOSTIC RESOURCES

A medical home is incomplete without access to specialty care. While CCHHS offers an array of specialty and diagnostic services, additional capacity for surgical and other sub-specialties will be needed. Mental health and substance abuse will be required given that the "newly eligible" will likely have significant needs in this area. CCHHS offers the following specialty services at Stroger Hospital for the CCHHS system as well as the broader safety net in Cook County. In developing the community partnerships, an emphasis on serving the needs of patients with mental health and substance abuse needs will be a critical component given the profile of the newly covered patients in the waiver. Figure III and IV lists an extensive sample of the specialty services and ancillary and diagnostic services currently offered by CCHHS.

Figure III. Sample of Specialty Services Offered by CCHHS

Specialty Care Services CCHHS	
Ophthalmology ENT Oral Surgery Colo-Rectal General Urology Neurology Neurosurgery Pediatric Urology Trauma Vascular Amputee Cardiology Cardio-Thoracic Surgery General Surgery Gastroenterology Minor Procedures Occupational Medicine Pulmonary Medicine Pulmonary/Occupational Medicine Renal Dermatology Dermatology/Moh's Procedures	GU Oncology Gyne Oncology Hemophilia Hematology-Oncology Medical Oncology Musculoskeletal Palliative Care Sleep Apnea Breast/Surgical Oncology Breast Screening Burn Hematology Liver Surgery Medical Oncology – Breast Surgical Oncology Soft Tissue/Melanoma Podiatry Hand Surgery Pediatric orthopedics Orthopedics Plastic Surgery Rheumatology

In addition to specialty services, CCHHS offers a full range of ancillary and diagnostic services.

Figure IV. Ancillary and Diagnostic Services Offered by CCHHS

Ancillary & Diagnostic Services CCHHS

Infusion Dialysis Mammography Ultrasound Radiology Physical Therapy Vascular Lab Nuclear Medicine	 Language Speech & Hearing Endoscopy Bronchoscopy Neurophysiology EKG/Cardiology

OPTIMIZING THE USE OF SPECIALTY AND DIAGNOSTIC RESOURCES

Specialty and diagnostic referrals are coordinated by the CCHHS-developed Internet Referral Information System (IRIS). This web-based system is the sole way of requesting CCHHS specialty and diagnostics from PCPs both within and external to CCHHS. IRIS features evidence-based rules to ensure appropriate referrals to specialty. When the system was first implemented, it rejected approximately 23% of referrals as inappropriate, i.e., otherwise resulting in a wasted visit. The system continues to strive to approve only appropriate visits, optimizing the use of these scarce resources.

CLAIMS PAYMENT

Providers will submit claims to HFS for waiver enrollees in the same way claims are currently submitted for other eligibility categories – primarily through electronic methods. In the waiver population there will be three distinct categories for the purpose of payment and claims processing:

- CCHHS Network (in-house) – the current CCHHS network as identified by current provider numbers;
- CCHHS Network (community partners) – CCHHS will secure agreements with a modest number of providers; and
- Out of Network – providers outside of the CCHHS Network (i.e. in-house and community partner) – with the exception of emergency services.

Claims for waiver enrollees will be processed through the HFS's MMIS system. In addition to all current edits in the MMIS system, a new edit will assure that non-emergency services provided to waiver enrollees are provided by CCHHS Network providers. Non-emergency claims from providers outside the CCHHS network will be denied. Waiver enrollees will require a separate eligibility category code. CCHHS will maintain and share with HFS a list of Cook County Network providers. HFS will send a provider notice to describe this new population and its network and reflect the network on its Medical Electronic Data Interchange (MEDI) system.

MMIS claims processing will result in approval or denial of claims. HFS will process all claims for CCHHS Network providers – both in-house and "community partners". HFS will process claims and notify CCHHS of each claim's disposition through current state processes or a process that is more convenient to the state. Payment for community providers may be at a rate less than the Illinois Medicaid rate as some rates will need to be vetted and approved between community partners, CCHHS and HFS given how the newly eligible revenue stream may impact the balance of how the costs uninsured are currently handled

for community providers. CCHHS and HFS will also make sure that coverage comports appropriately with the disproportionate share revenues that CCHHS receives from HFS. The waiver will provide coverage of emergency services provided in hospital emergency rooms for emergency medical conditions, and/or required post-stabilization care, regardless of whether the provider that furnishes the services is within the CCHHS network.

- CCHHS may pay for emergency services and post-stabilization services provided by out-of-network providers at a percent of the applicable regulatory fee-for-service rate under the Illinois State plan. The out-of-network provider will accept the program payments made in accordance with the waiver's terms and conditions as payment in full for the services rendered and the waiver recipient may not be held liable for payment.
- Out-of-network providers will, as a condition for receiving payment for emergency services, notify CCHHS within 24 hours of admitting the patient into the emergency room, and, with respect to post-stabilization care, meet the approval protocols established by the waiver.

While payment methodologies will be discussed in more detail in Section VII, Budget Neutrality and Cost Reconciliation, it is worth noting that CCHHS will submit annual cost reports indicating the costs incurred in providing care to waiver enrollees to HFS. These reports will be in cost-to-charges format required by other governmental payers. HFS will review cost reports to determine if they are complete, accurate to the best of the state's knowledge, and consistent with requirements for federal financial participation on certified public expenditures. With HFS's approval of annual cost reports and reconciliation, HFS will ensure that CCHHS receives no reimbursement more than the waiver population's cost under Medicare cost-based principles.

V. PROPOSED CARE MANAGEMENT PLAN

CCHHS has adopted a strategic plan that is consistent with a PCMH system of care with the following key elements of the plan directly supporting care management:

- Shifting to a population-centered vs. hospital-centered health delivery model;
- Enhancing accessibility to services;
- Aligning service delivery with population demand for services;
- Building specialty care capability (and using that capacity in a clinically appropriate fashion);
- Extending primary care services through partnerships;
- Providing quality-cost effective health care; and
- Focusing on service excellence, employee satisfaction, and leadership development.

CCHHS has committed to several quality improvement activities consistent with the PCMH model; the waiver will provide an opportunity to expand upon and sustain these efforts. In addition, the waiver will provide support for the CCHHS to prepare for Illinois House Bill 5420, which is the legislation enacted in January 2011 that establishes care coordination provisions for CHIP, AllKids and Medicaid in Illinois. The law included the following provisions:

- Requires at least 50 percent of statewide recipients eligible for comprehensive medical benefits to be enrolled in a risk-bearing care coordination program by January 1, 2015;
- Defines coordinated care as "delivery systems where recipients receive care from providers participating under contract in integrated delivery systems that are responsible for providing for or arranging for the majority of care;"
- Establishes that payment for coordinated care will be pay-for-performance (health care outcomes, evidence based practices, use of primary care, EMRs, electronic health information exchange) on a capitated basis with full financial risk or through other risk-based payment arrangements; and
- Requires that to achieve 50 percent goal enrollment, care coordination programs must include individuals from each medical assistance enrollment category (parents, children, seniors, and people with disabilities).

The Medical Home Network (MHN), a non-profit, Chicago-based provider network that seeks to improve access, quality and cost of care, will serve as a complement for CCHHS in the southern Chicago area (and possibly other areas of Cook County) to serve the waiver population. MHN targets the TANF and ABD fee-for-service population; they are all assigned to a medical home under the State's Illinois Health Connect (IHC) program. CCHHS will bring MHN functionality to coordinate care for the newly covered waiver population as well. This includes sophisticated data analytics and real time connectivity that allows notifications of partner hospital ER and inpatient activity. In addition, CCHHS plans to support primary care services for the portion of the waiver population among selected MHN-partner FQHCs. These patients will also receive the benefits of MHN's care coordination services.

The CCHHS Care Management Program will be designed to initially serve the IHC and waiver populations with the intention of serving all CCHHS patients in this fashion as soon as is feasible to ensure integrity of practice.

GOALS AND VISION OF THE CARE MANAGEMENT PROGRAM

The goals of a CCHHS Care Management Program are to improve health outcomes of the CCHHS patient population, enhance patient experience of care and reduce the costly burden of uncoordinated health services**.** CCHHS will use a nationally accepted model of the PCMH for a care coordination plan as the ultimate vision for primary care practice. The waiver population will receive care management that is integrated into the primary care services within CCHHS's primary care network of 16 primary care sites. Primary care will be supported by CCHHS's specialty, diagnostic and inpatient services as well as a closed network of behavioral health providers.

A central assumption that informs the vision of the Care Management Program is that medical practices are not able to deliver separate models of care for separate populations. In order to deliver the triple aims of better patient experience, lower cost and improved population health, the delivery of primary care and care management must be done for the entire set of patients for which a care team is responsible. Empaneling approximately 1,500 patients to each medical home team, CCHHS will begin

with a smaller number of primary care providers and ramp us as enrollments increase. CCHHS will eventually adopt the model System-wide.

Delivering a single high quality model of care for the patient population is consistent with the paradigm shift in health care delivery from individual and event-focused metrics to quality outcomes and cost containment across entire populations. Payment approaches in Medicaid and Medicare are moving from fee for service (individual events) to a per person (bundled/capitated) arrangement with controls for quality and patient experience. To succeed in this new population focused approach in which financing rewards the improvement of quality and satisfaction, while containing costs, local primary care practices must be the cornerstone of accountability. In this context, CCHHS is committed to developing high-functioning PCMHs as the model of care along with the administrative structure to support care management at varying levels of service for the population based on their risk and complexity.

Patients will be assigned and linked – empaneled - to a PCMH team that will provide ongoing care for a defined panel of patients and will be accountable for the health of that patient population. Staffing and support for the PCMH teams will be informed by the composition of the patient panel in terms of complexity and risk for future utilization and/or poor health outcomes. A standardized approach to care management, including integration with behavioral health, will be developed centrally and implemented by the PCMH team. PCMH teams will be assisted by an Advanced Illness Management (AIM) team for particularly complex patients with a poor health status.

The approach will be supported by an electronic population health management application that will provide alerts to help ensure timely preventive care, chronic disease management, and transition care. The vision is that this application will also be used by network behavioral health providers, allowing for a shared care plan. Care processes and population health outcomes will be measured and used for purposes of continuous quality improvement.

EMPANELMENT

As discussed above in the vision, each PCMH team will be responsible for a defined set of patients. The number of patients assigned to a given provider must be “right sized,” adjusting for the need for office visits and the complexity of those visits. Care management resources will be matched to the needs of the resulting panel. Implicit in the need to assign patient panels to each care team is an enrollment process. This will certainly be the case for the waiver population but must also be so in some manner for the entire set of patients over time.

CCHHS will use a patient management system application to maintain the patient to PCP associations. These PCP associations will be reflected in the demographic banner of the CCHHS EMR. In general, patients will be scheduled only with this team to ensure continuity of care. The PCMH team will be responsible for all of the care management for most of their patient panel. Some patients will require complex case management. In these cases some of the care management will occur in a physical location outside of the PCMH team but with continued communication and a care plan shared between the complex case management entity and the PCMH.

CARE MANAGEMENT APPROACH

Care management is a patient-centered, team-implemented, outcomes-oriented process. Care Management is a program of coordinated activities focused on patients' goals and needs. The program has three primary domains: preventive health care maintenance, chronic disease management, and transition care. These domains are supported by a set of defined, standardized, and ongoing care management functions.

The care management program is delivered primarily from the PCMH by experienced nurses, social workers, and other licensed and non-licensed professionals with leadership from the primary care provider. In CCHHS, a nurse care manager will serve as a central member of each medical home team. While the care management effort will be led by the nurse care manager, all team members will participate in care management with particular roles designated for each team member.

Proactive screening is used to identify high-risk patients. The care manager provides a higher level of service intensity to a small percentage of high risk/high cost patients. He/she works with the team to develop a care plan for the patient, and provides self-management support and motivational interviewing to ensure a high level of patient engagement in self-care. The care manager works to coordinate care and communicates with the patient, PCP, health care team and specialty care providers.

The PCP identifies and refers patients to the care manager for provision and/or coordination of additional services such as self-management support, chronic disease education, and reinforcement of medication adherence. The care coordinator assists in gathering and entering data. The care coordinator completes tasks that are appropriate for its level of training such as conducting outreach calls to bring patients in for preventive health screening or labs, or scheduling follow-up appointments after an ED visit or hospitalization.

POPULATION HEALTH MANAGEMENT APPLICATION TO SUPPORT CARE MANAGEMENT

Although not a significant factor in the present reimbursement system, health care reimbursement will be increasingly tied to quality outcomes. A Population Health Management (PHM) application can improve quality measures and reduce staff time and expense. At the practice level, a PHM system tied to the Electronic Medical Record (EMR) is the informatics backbone.

In CCHHS's Cerner Office application, data can be queried but there are certainly limitations. Patients who are overdue for preventive screening tests can be identified or patients with a chronic disease who need a single lab test can be found, though only with some difficulty and only individually unless a customized report is generated. For example, identifying patients with diabetes who are overdue for an appointment, do not have an appointment scheduled, and are outside the targets for three common lab tests would require four separate queries and then manual reconciliation. It would be a cumbersome process and the effectiveness would be difficult to monitor. Moreover, there would be numerous uncoordinated queries/processes ongoing to track the many preventative and chronic disease metrics.

The PCHM system, when interfaced with an EMR, provides a comprehensive tool-set for identifying populations of patients, engaging them in their care, documenting encounters, and reporting on

demand. For performance improvement efforts, the care team has access to data for each population and sub-population, making it possible to measure the effectiveness of interventions and spread those that prove successful. While the EMR is focused on capturing the data, the PHM system aggregates data and supports action.

There are a number of PHM Systems that are taking hold across the country: i2i Systems, WellCentive, and DocSite are among the leaders. CCHHS will look at existing registries and consider in-house but will make an informed decision about the most effective, and cost-effective, direction.

WEB-BASED COMMUNICATION SYSTEMS TO SUPPORT CARE COORDINATION: PARTNERSHIP WITH THE MEDICAL HOME NETWORK

The MHN, described earlier, is implementing MHNConnect, a web-based platform to enhance care coordination among its member organizations. The portal will be implemented in both primary care practices and hospitals to facilitate bi-directional communication. The solutions being utilized in the near term include:

ECEDA – Aggregates real time HL7 ADT data from participating hospitals (hospital admissions and discharge; and emergency room activity).

ER CONNECT – Provides pertinent patient data to ER physicians at the point of care via historical claims and filled prescription claims.

EREFERRAL/IRIS – Facilitates electronic referral for health services, behavioral services, and in the future, community-based social services.

ECONSULT – Facilitates electronic “curbside” consult allowing for providers to interact in a secure messaging environment. Information exchanged is used to service the patient in a more time effective and focused manner.

These solutions will help ensure efficient communication and coordination between primary care, specialty care and tertiary care. For example, patients enrolled in a CCHHS PCMH may be seen in the emergency department or admitted to a hospital either within CCHHS or in another facility. For the medical home to be effective in preventing readmissions and unnecessary repeat emergency department visits, the team will need to be reliably alerted to patient utilization in these settings.

An HL7 ADT feed is used which doesn’t require the hospital/ED to do anything but register the patient for the notification to be sent. The electronic notification is sent to the medical home in near real time, allowing (the medical home) it to arrange timely outpatient follow-up which (quickly bring patients in to help) reduces the risk of readmission and inappropriate repeat emergency room visits. Linking MHN Connect through a web-based population health management application will facilitate ease of use by the provider team. In addition, MHN accesses disparate data sources to integrate medical claims and filled prescription claims and delivers that information directly to providers.

MHN has developed reporting tools for the participating organizations to better manage care and manage costs. These reports will help MHN and CCHHS identify clinical improvement and care management opportunities, drive performance improvement, and identify cost savings.

CARE MANAGEMENT PROGRAM ORGANIZATION

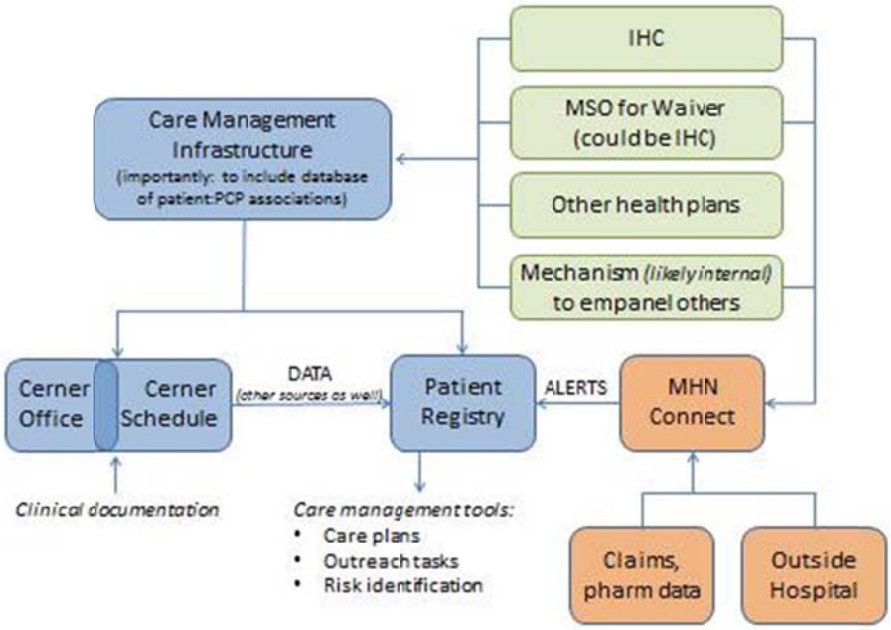
The reorganization of the delivery system towards population health will require administrative infrastructure at CCHHS as well as a redefinition of roles and responsibilities in the medical home. A Director of Care Management will direct a training and competency assessment team and will have indirect supervision of the care managers as depicted in the diagram below.

The care managers may be contractual employees or nurses already in the system, with significant training in either case. CCHHS will engage a team of external trainers/coaches to support the development of internal capability to take on these new roles as well as assess care manager competencies.

A care manager will be able to cover a population of between 250 and 10,000, depending on the level of complexity of the patient population. A typical licensed care manager interaction with a patient will be 10 to 30 minutes (includes activities such as disease self-management education and goal setting). This allows for over 5,000 meaningful interactions per year per FTE of this role (an FTE nurse will likely take on other roles as well). A patient with several chronic diseases and mental health challenges might require monthly interaction and this would require a ratio of 1:250 patients. A well child may only need licensed care management interaction (e.g. educating a parent/child on developmental expectations) once every other year on average requiring a ratio of 1:10,000 patients. The population health management system can estimate the staffing ratio required for the actual patient population.

In summary, the diagram depicts the proposed Care Management Program organization highlighting the interrelationship of each of the component parts. These include empanelment of the patient population in medical homes, care management staffing infrastructure, a Population Health Management system that provides actionable data drawn from Cerner Office, and MHN Connect – a web-based communication system that supports care coordination and decision support linked through a patient registry.

The proposed waiver will prepare CCHHS for new payment and health care delivery expectations, including strengthening patient centered medical homes, and expanding the County's initiatives to coordinate the delivery of high-quality care.



VI. STAKEHOLDER INPUT

CCHHS has begun the stakeholder input process. The first level of this has been an introduction of the concepts and the concept paper itself in some cases to a variety of interested parties including the CCHHS in-house staff, representatives from the labor community, selected health foundations in the Cook County region, state and federal legislators, patient advocates, providers and others. The next step will include a public notice of intent to seek an 1115 demonstration waiver. Tribal notifications will be sent if applicable. Notifications will be handled through the Illinois register and/or other appropriate mechanisms. Some of the other stakeholder input activities will include:

- Convening a series of public meetings and/or community events that explain the key components of the waiver in a more coordinated fashion since the concept paper and waiver have progressed. Meetings will be directed towards medical providers, patient groups, provider groups, and others. Meeting will be open meetings;
- Receiving and reporting on public comments with respect to the public notice and public meetings;
- Medicaid notices will be sent to clients as well as enrollment packets; and
- Training sessions will be held for staff or providers if necessary.

VII. BUDGET NEUTRALITY AND COST RECONCILIATION

ESTIMATES OF THE COST OF THE PROGRAM USING MSIS AND DATA CRAFTED FROM HFS AND MILLIMAN ACTUARIAL SERVICES

CCHHS WAIVER-SPECIFIC WORK

To arrive at per-member-per-month (PMPM) costs for the CCHHS waiver population, MSIS data on unique beneficiaries and total Medicaid paid amounts were compiled for Illinois-specific Medicaid recipients in the blind/disabled, adult, and unemployed adult population. Medicaid payments were broken down by service type and grouped into the following PMPM categories:

- Inpatient hospital,
- Outpatient hospital,
- Pharmacy,
- Physician,
- Transportation, and
- Other services.

These PMPM costs were compared against data prepared for Illinois HFS's 2011 Integrated Care Program (ICP) operating in the suburban zip codes of Cook County and in the counties adjacent to Cook County. Milliman, Inc. was retained by the State of Illinois to provide actuarial services in the ICP procurement process, including PMPM rate analysis and development. While the different data sources make it difficult to achieve a granular comparison across all categories of service as components of a PMPM rate, the MSIS PMPM rates for the ABD (blind/disabled) population reasonably approximate the projected rates prepared by Milliman for the Community Residents population in FY 2010-2011, which includes non-dual, non-institutionalized, non-waiver aged, blind, and disabled persons in the counties mentioned above. Total PMPM rates differ by a small percentage with individual categories of service comparing similarly as well, including inpatient hospital and clinic services. Based on this confirmation from an actuarial analysis of a similar population, the MSIS data was deemed to be reliable and used to develop estimated PMPM rates based on a benefit package of covered services for the CCHHS target population.

PER-MEMBER-PER-MONTH RATE AND BUDGET METHODOLOGY

We request that budget neutrality be measured with a per capita cap. The "without-waiver" ceiling for each year will be equal to the following – the number of expansion eligibles multiplied by an agreed-upon per member per month allowance. The "without-waiver" per member per month allowance will be based on an estimate of CCHHS expenditures for the proposed benchmark package included in the waiver application. In developing the PMPM amount, we considered estimates published by the Urban Institute, CCHHS expenditure data for the uninsured population, and Illinois Medicaid expenditure data for adults, blind/disabled, and unemployed adult population categories. The "with-waiver" expenditures will consist of costs for actual expenditures for waiver enrollees. For details on data sources, including the CMS Medicaid Statistical Information System (MSIS), please see Appendix I.

PROPOSED PMPM RATES FOR JULY 2012 – JUNE 2013 AND JULY 2013 – DECEMBER 2013:

- July 2012 – June 2013: $379.04
- July 2013 – December 2013: $393.14

PMPM, ENROLLMENT, AND COSTS: JULY 2012 – DECEMBER 2012

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
PMPM	$ 379.04	$ 379.04	$ 379.04	$ 379.04	$ 379.04	$ 379.04
Enrollment	1,000	3,000	5,000	7,000	9,000	11,000
Monthly Cost	$ 379,040	$ 1,137,121	$ 1,895,201	$ 2,653,282	$ 3,411,363	$ 4,169,443
Cumulative Cost	*$ 379,040*	*$ 1,516,161*	*$ 3,411,363*	*$ 6,064,645*	*$ 9,476,007*	*$ 13,645,450*

PMPM, ENROLLMENT, AND COSTS: JANUARY 2013 – JUNE 2013

	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
PMPM	$ 379.04	$ 379.04	$ 379.04	$ 379.04	$ 379.04	$ 379.04
Enrollment	17,000	23,000	29,000	37,000	45,000	53,000
Monthly Cost	$ 6,443,685	$ 8,717,927	$ 10,992,168	$ 14,024,491	$ 17,056,813	$ 20,089,135
Cumulative Cost	*$ 20,089,135*	*$ 28,807,062*	*$ 39,799,231*	*$ 53,823,721*	*$ 70,880,534*	*$ 90,969,670*

PMPM, ENROLLMENT, AND COSTS: JULY 2013 – DECEMBER 2013

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
PMPM	$ 393.14	$ 393.14	$ 393.14	$ 393.14	$ 393.14	$ 393.14
Enrollment	63,000	75,000	87,000	99,000	111,000	125,000
Monthly Cost	$ 24,767,695	$ 29,485,351	$ 34,203,008	$ 38,920,664	$ 43,638,320	$ 49,142,252
Cumulative Cost	*$ 115,737,365*	*$ 145,222,717*	*$ 179,425,724*	*$ 218,346,388*	*$ 261,984,708*	*$ 311,126,961*

Blended PMPM rates for the target population were calculated based on the following assumptions:

- Service category PMPM costs were calculated from MSIS based on a strict basis of cost divided by total beneficiaries divided by twelve months.
- Those service categories excluded from the assumed benefit package were dropped from calculation (see Figure V below).

Figure V. Included Services by MSIS Categories

Included Benefits	Excluded Benefits
INPATIENT HOSPITAL	NURSING FACILITY
DRUGS	ICF-MR
PHYSICIAN	PERSONAL CARE
OUTPATIENT HOSP.	PRIVATE DUTY NURSE
CLINIC	STERILIZATION
LAB AND X-RAY	MIDWIFE
CASE MGMT.	ABORTION
TRANSPORTATION	DENTAL
NURSE PRACTITIONER	HOSPICE
OTHER PRACTITIONER	THERAPY AND REHAB
OTHER SERVICES	HOME HEALTH

- Included service PMPMs were summed to a total rate for both the Adult population and the Blind/Disabled population.
- These populations were weighted based on a case mix of 70% Adults, 30% Blind/Disabled. This blended rate becomes the average PMPM for FY 2010. Based on the 70/30 split, annualized December 2013 PMPM costs for one member amount to $4,780. The May 2010 report prepared

by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured estimates net new Medicaid enrolled adults and total costs of these enrollees over the 5-year 2014-2019 period. The average annual cost of a Medicaid enrollee over this 5-year period is $6,485. The author, John Holahan, utilizes MSIS data, as well as proprietary health care simulation modeling, to derive these estimates.

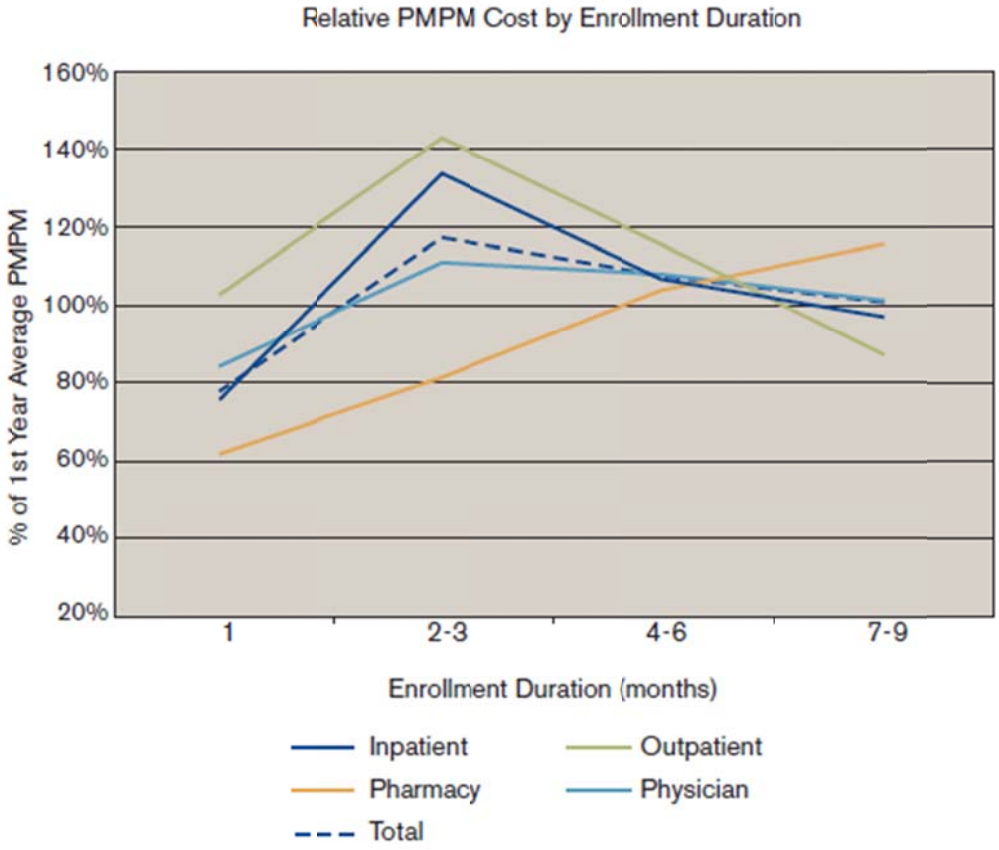
- The proposed PMPM rates use a trend rate of 5% annual increase in expenditures. These assumptions will be adjusted based on Medicaid trend rate assumptions included in the President's Budget. As a point of comparison, provided PMPM trend rates for annual cost growth from Milliman actuarial work for HFS's 2011 Integrated Care Project vary from as low as 1% annually for inpatient hospital services, to as high as 10% annually for outpatient hospital services.
- Month by month waiver enrollment assumptions follow a gradually accelerating rate of enrollment increases over the 18 month period, achieving total enrollment of 125,000 by December 2013.

KNOWN LIMITATIONS IN METHODOLOGY

It is very difficult to estimate costs for a population that is not currently served in a coordinated manner. Whereas CCHHS knows that well over $400 million in services are provided to the uninsured annually (at Stroger alone) and that there are more than 180,000 unique recipients served, the current care that is delivered lacks continuity given the nature of the population. The monthly cost calculations do not specifically account for the impact of pent-up demand in the waiver population. However, the 70/30 acuity adjustment plays a factor in trying to account for pent-up demand.

Pent-up demand is clearly an issue that CCHHS and HFS will be monitoring closely. As an example, the Healthy Indiana Plan found a nine-month period of increased PMPM costs after initially enrolling previously uninsured individuals in the plan. The PMPM costs in the table below are derived from commercial insurance costs, so correlation with Medicaid utilization is limited. However, this does indicate the likelihood of a spike in utilization and associated costs in the initial year of enrollment.

Figure VI.



Source: Milliman, Inc. "Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured." August 2009. http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf

COST-BASED INTERIM REIMBURSEMENT METHODOLOGY AND RECONCILIATION

In addition to the PMPM methodology, perhaps an equally important point is the clarification that the waiver will be a cost-based interim reimbursement methodology with reconciliation to cost.

While estimating the cost of the waiver will be important for a variety of purposes, the cost-based methodology and reconciliation will provide assurance that the federal government is paying no more than cost (based on reimbursement methodologies that are supported by Medicare cost report principles). Key components that will provide the assurance that the federal government is paying no more than cost include:

- Crafting interim rates from publicly available Medicare (and Medicare based) cost reports;
- CCHHS will establish a unique financial class within its internal system to track the waiver members charges, utilization, and reimbursement; and
- Reconciling rates to cost.

It is a fundamental premise of this waiver that waiver services will be federally matched at the regular FMAP rate until 1-1-2014 when services will be matched at the appropriate ACA matching rate – beginning at 100%. CCHHS has hopes to move towards reimbursement that is tied more or related to clinical outcomes or a bonus payment structure tied to outcomes. Given HFS's policy direction, CCHHS will need eventually to work within the waiver, and outside the waiver, to move its system to comport with HFS's policy direction and bundled payments. The waiver provides an impetus to move in that direction.

HOSPITAL REIMBURSEMENT PROPOSAL

INPATIENT SERVICES

Inpatient Hospital Services will be reimbursed based upon the cost of providing the services. An interim payment rate will be established. The interim rate will be based upon data contained in the latest filed Medicare cost report and will be updated upon each subsequent years as filed cost report. The current rates will likely be based upon County Fiscal year 2010 rates. The following actions will be taken to support the development of an interim payment rate:

- Departmental cost to charge ratios will be developed for each ancillary cost center and the cost to charge ratios (per the Medicare cost reports) will be amended to include the cost of medical education. The cost to charge ratios will be applied to the departmental waiver member care charges to arrive at the waiver member care ancillary costs;
- The appropriate cost per diems will be developed (i.e. routine, special care, nursery, etc.) and will be applied to the waiver member care days within the unit to arrive at the waiver member care room and board costs; and
- The waiver member care ancillary and room and board costs will be combined and divided by total waiver member care days to arrive at an interim per diem rate.

An interim payment will be made based upon the interim per diem rate. Upon submission of a hospital inpatient bill for a waiver covered patient, the interim per diem rate will be applied to the number of days reported on the bill to arrive at the interim payment. CCHHS will be required to use an identifier on the bill to identify the claim as one related to a waiver covered member. CCHHS will bill in batches that will be submitted to HFS on a weekly basis or whatever time increment is convenient for the HFS.

A year end reconciliation of the actual costs of providing the services to the waiver members and interim payments received by CCHHS will be made. CCHHS will establish a financial class within its internal system to track the waiver members' inpatient charges, days and payments. The reconciliation will be made based upon the filed Medicare cost report which is submitted by April 30 of each year. It is expected that the reconciliation will be completed by the following summer and an amount due the CCHHS or due the HFS/CMS will be calculated. CCHHS will submit any payments due the State within 90 days of receiving notification of an overpayment. The State will make payment to the hospital within 90 days of the determination of an underpayment to CCHHS.

OUTPATIENT SERVICES Hospital based outpatient services will be reimbursed based upon the cost of providing services to the waiver members. An interim payment rate will be established using departmental cost to charge ratios that are developed on the Medicare cost report. The cost to charge ratios (per the Medicare cost reports) will be amended to include the cost of Medical education. The costs and charges of each of the ancillary cost centers will be totaled and an overall ancillary cost to charge ratio will be calculated.

Upon submission of a CCHHS outpatient bill for a waiver member, the interim cost to charge ratio will be applied to the charges reported on the bill to arrive at the interim payment. CCHHS will be required to use an identifier on the bill to identify the claim as one related to a waiver member. CCHHS will bill in batches that will be submitted to HFS on a weekly basis or whatever time frequency is convenient for HFS.

A year end reconciliation of the actual costs of providing the services to the waiver members and the interim payments received by CCHHS will be made. CCHHS will establish a financial class within its internal system to track the waiver members' outpatient charges and payments. The reconciliation will be made based upon the filed Medicare cost report which is submitted by April 30 of each year. It is expected that the reconciliation will be completed by the following summer. An amount due to CCHHS or due to HFS/CMS will be calculated. CCHHS will submit any payments due the State within 90 days of receiving notification of an overpayment. HFS will make payment to the hospital within 90 days of the determination of an underpayment to CCHHS.

PRIMARY CARE HEALTH CENTERS

CCHHS operates both hospital -based and community-based health centers. These services for the waiver population will be reimbursed on a cost basis. An annual cost report is completed for each of the clinics. The clinic cost reports are prepared using the hospitals Medicare cost report and census data for each of the clinics to calculate a cost per visit. An interim payment rate will be established using the per-visit rate developed on the clinic cost reports. The per-visit rate will include the cost of medical education.

Upon submission of a clinic bill for a waiver member, the interim per visit rate will be applied to the number of visits reported on the bill to arrive at the interim payment. CCHHS will be required to use an identifier on the bill to identify the claim as one related to an uninsured. CCHHS will bill in batches that will be submitted to the HFS on a weekly basis or whatever frequency is convenient for HFS.

A year end reconciliation of the actual costs of providing the services to the waiver members and the interim payments received by CCHHS will be made. CCHHS will establish a financial class within its internal system to track the waiver members' outpatient charges and payments. The reconciliation will be made based upon the filed Medicare cost report which is submitted by April 30 of each year. It is expected that the reconciliation will be completed by the following summer. An amount due to CCHHS or due to HFS/CMS will be calculated. CCHHS will submit any payments due the State within 90 days of receiving notification of an overpayment. HFS will make payment to the hospital within 90 days of the determination of an underpayment to CCHHS.

VIII. MEASUREMENT AND QUALITY

In addition to understanding the financial impact of the waiver, HFS, CCHS, and CMS will need information on the extent to which the waiver population has been successfully enrolled, is accessing services, and is receiving care consistent with quality standards. This section describes a preliminary plan for measurement and evaluation. Following California's example, we propose a complete evaluation plan be developed within 120 days of the waiver being approved. However, for discussion purposes, we have outlined an evaluation that assesses the extent to which the program meets the following goals:

1. Enrollment of 250,000 previously uninsured low-income adult residents of Cook County into Medicaid;
2. Access to needed care;
3. Receipt of coordinated care through a medical home, and reduced inappropriate use of care that comes from poor access and care coordination, including preventable hospitalizations and ED use, and readmissions; and
4. Patient satisfaction with coverage and care.

An independent evaluator, perhaps from University of Illinois or another academic organization, will be asked to develop the evaluation plan further, particularly comparing the available data to the measures proposed below.

MEASURES

ENROLLMENT

The evaluator will use enrollment files to track monthly progress towards enrolling the target population. By looking at age, income, and disability, we will be able to track which groups are represented in the new enrollees.

ACCESS TO NEEDED CARE

The evaluator will examine rates of health care service utilization, compared to a similar adult population not in the demonstration, to determine if rates of visits to primary, specialty, and behavioral health providers are consistent with access standards.

RECEIPT OF COORDINATED CARE THROUGH A MEDICAL HOME

The evaluator will use claims data to examine patterns of health services utilization and benchmark them against other enrolled low-income adults as well as national benchmarks for quality indicators such as HEDIS®. HFS already uses a set of quality standards to monitor health care utilization for Illinois Health Connect enrollees, and the adult indicators are well-suited to the new population. They include:

- Having a primary care visit in the past 12 months,
- Diabetes management (details to come),
- Asthma management,
- Cancer screening (breast, cervical),

- Smoking cessation,
- BMI assessment, and
- Treatment for mental illness/substance abuse.

HFS and CCHHS may want to consider expanding on the IHC measures for this waiver population. CMS released a set of adult core measures in January 2012, and several of those are relevant, and provide an opportunity to benchmark against other states using them. For example, CMS intends for states to track preventable hospitalizations and preventable emergency department visits, as well as readmissions. All are signals of failure to appropriately manage a patient's care in the outpatient setting. They are also costly and will impede the program's ability to achieve cost savings.

The measures used by IHC, and most of those proposed by CMS, can be collected using claims data, and data specifications exist. It is also worth considering whether new, better measures could be obtained from CCHHS's EMR; the evaluator could explore the possibility of programming the system to generate the needed population data from the EMR. Over the next few years, the state will be collecting more information from medical records and to the extent the state uses existing quality measures, comparison data are available for similar but not identical populations enrolled in Medicaid, using the state's data warehouse.

Care coordination will be measured in a manner consistent with Illinois' statewide care coordination program. Possible added measures will include:

- Contact between the discharging hospital and the medical home within 24 hours of a hospital discharge;
- Follow up after hospitalization for mental illness; and
- Screening for alcohol misuse.

A fourth health home measure, readmissions, was noted above.

PATIENT SATISFACTION WITH COVERAGE AND ACCESS

CCHHS currently contracts with a vendor for a patient satisfaction assessment. This will be considered by HFS and CCHHS when determining the appropriate direction going forward for the Evaluator. The Evaluator will conduct a telephone survey of new enrollees to gauge their experiences with coverage, their medical home, and the care coordination services. The survey will include questions about past health care utilization to understand where care was received prior to enrollment, and the extent of enrollees' unmet needs. The Illinois Health Connect program will be adopting the CAHPS survey in 2012, and we propose that many of the same questions be used in order to draw comparisons.

In addition to the four sets of measures above, which are focused on the patient's experience, we recommend the evaluator assess the extent to which practices serving new enrollees are functioning as patient-centered medical homes. There are several medical home assessments available, the most widely used of which is from the National Committee for Quality Assurance (NCQA). The evaluator could contract with practices to have them submit their data to NCQA for determination of "medical homeness," and the data could be used for the evaluation and correlated with health care utilization. A

project under way in Illinois, funded under the Children's Health Insurance Program Reauthorization Act (CHIPRA), is partnering with NCQA in this manner. Information garnered from this assessment can help the state in designing delivery systems to serve this population outside of Cook County. The evaluator could also study correlations between patient outcomes and medical home features, to determine which medical home features are the most important to achieving high quality care.

REPORTING

The evaluator will report quarterly on enrollment, utilization, and reduced inappropriate utilization of services, and will present trends along with a discussion of the circumstances thought to contribute to them. We will report on care coordination and patient satisfaction annually, comparing the new enrollees to other enrolled adults.

IX. PRELIMINARY LIST OF WAIVERS AND FLEXIBILITIES SOUGHT UNDER THE DEMONSTRATION

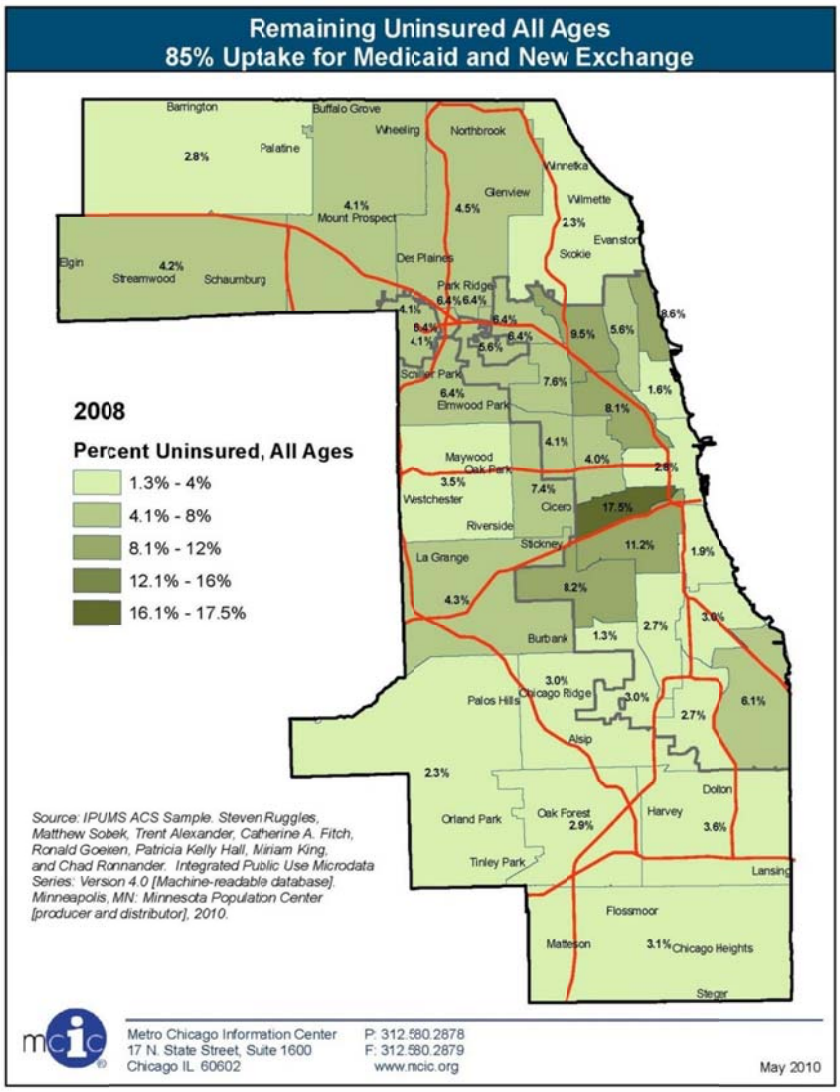
- *Amount, Duration, and Scope* - To enable the State to offer benefits that vary from the State plan [Section 1902(a)(10)(B)]
- Freedom of Choice - To enable the State to restrict freedom of choice of provider [Section 1902(a)(23)]
- Statewideness - To enable the State to operate the Demonstration and implement coverage for new eligibles in Cook County. [Section 1902(a)(1)]
- *Retroactive Eligibility* - the HFS and CCHHS may request some reconfiguration of the traditional retroactive eligibility standards.
- *Comparability of Eligibility Standards* – To permit the state to apply differences in eligibility standards for Cook County for the Demonstration program. [Section 1902(a)(17)]
- *Presumptive Eligibility* - Section 2202 of the Affordable Care Act (ACA) inserts into Social Security Act Section 1902(a)(47) a statement that any hospital acting as participant in the State's plan may elect to be qualified entity for the purpose of determining, on the basis of preliminary information collected, whether any individual is eligible for either medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period. This expansion of Presumptive Eligibility to all Medicaid eligibility categories is effective January 1, 2014.

X. CONCLUSION

The purpose of this waiver is to build a bridge to the 2014 eligibility expansion that will take place under ACA, by increasing coverage and strengthening the provider network. In concert with efforts already underway in the County and state, the waiver will support delivery system improvements that will benefit patients while making care more efficient. This expansion will enable the County to secure financing that reflects the realities of the provider system, to improve and prepare the health care infrastructure to serve a newly insured population that will have more choices, and to address the unsustainable conditions it currently faces while better serving a key population in need.

APPENDICES

APPENDIX I: ESTIMATED COOK COUNTY UNINSURED BEFORE AND AFTER HEALTH REFORM IMPLEMENTATION



APPENDIX II: DATA SOURCES AND COMPARISON

The CMS Medicaid Statistical Information System (MSIS) DataMart collects state data files, submitted quarterly, including one file which contains eligibility and demographic characteristics for each person enrolled in Medicaid at any time during the quarter, and four separate files of claims adjudicated for payment during the quarter for long-term care services, drugs, inpatient hospital stays and all other types of services. The state-submitted data include over 40 million eligibility records and over 2 billion claims records per year. The data are subject to validation edits which test whether individual data fields are within appropriate ranges and then distributional quality checks to evaluate the reasonableness of the information across data elements and quarters.

After the edits are complete, the files accepted by CMS are loaded into a granular data warehouse. The State Summary DataMart has been developed to extract pre-aggregated data from the granular tables for pre-determined dimensions and measures and display the aggregated statistics for analysis. For each fiscal year, quarterly and monthly data cubes were built which contain measures and dimensions of the most commonly asked statistical questions. This system was developed to answer all research questions, but CMS believes that the mart provides much needed support to States and others who have a need to obtain State-specific and/or national data quickly and efficiently.

The quarterly data cube includes summary information on Medicaid eligibility and utilization and contains the following dimensions: State, period (quarterly or annual), age group, race, sex, MAS (maintenance assistance status), BOE (basis of eligibility), dual eligibility status, SCHIP status, program type, plan type, service category, service type, claim type, and adjustment indicator. The available measures are: unique eligible count, unique beneficiary count, total claims count, total Medicaid paid amount, encounter total claims count, unique encounter beneficiaries count, unique enrollees, total days of care count, and IP discharge total count.

APPENDIX III: PMPM COST TAB LES

PMPM COST TABLES: JULY 2012 – JUNE 2013; JULY 2013 – DECEMBER 2013

	Jul-12 to Jun-13	Jul-13 to Dec-13
BLENDED PMPM	**379.04**	**393.14**
INPATIENT HOSPITAL	**118.62**	**123.04**
OUTPATIENT HOSPITAL	**38.82**	**40.27**
PHARMACY	**76.16**	**78.99**
PHYSICIAN TOTAL	**67.47**	**69.98**
PHYSICIAN	37.91	39.32
CLINIC	13.88	14.40
LAB/X-RAY	13.27	13.76
NURSE PRACTICIONER	1.44	1.50
OTHER PRACTICIONER	0.96	1.00
OTHER SERVICES	**72.03**	**74.71**
CASE MGMT	1.12	1.16
ALL OTHER	70.92	73.55
TRANSPORTATION	**5.94**	**6.16**
BLIND/DISABLED PMPM	**808.34**	**838.40**
INPATIENT HOSPITAL	**267.83**	**277.79**
OUTPATIENT HOSPITAL	**63.07**	**65.41**
PHARMACY	**145.75**	**151.17**
PHYSICIAN TOTAL	**82.85**	**85.93**
PHYSICIAN	50.53	52.40
CLINIC	16.49	17.11
LAB/X-RAY	13.51	14.01
NURSE PRACTICIONER	0.86	0.89
OTHER PRACTICIONER	1.47	1.52
OTHER SERVICES	**232.38**	**241.03**
CASE MGMT	3.17	3.29
ALL OTHER	229.21	237.74
TRANSPORTATION	**16.45**	**17.06**
ADULT PMPM	**195.06**	**202.31**
INPATIENT HOSPITAL	**54.68**	**56.71**
OUTPATIENT HOSPITAL	**28.44**	**29.49**
PHARMACY	**46.33**	**48.05**
PHYSICIAN TOTAL	**60.87**	**63.14**
PHYSICIAN	32.50	33.71
CLINIC	12.76	13.23
LAB/X-RAY	13.17	13.66
NURSE PRACTICIONER	1.69	1.76
OTHER PRACTICIONER	0.75	0.78
OTHER SERVICES	**3.31**	**3.43**
CASE MGMT	0.24	0.25
ALL OTHER	3.07	3.19
TRANSPORTATION	**1.43**	**1.48**