Innovations Project: Overview

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State of Illinois Goal

- A redesigned health care delivery system that is more patient-centered, with a focus on improved health outcomes, enhanced patient access, and patient safety

To achieve that goal, the state must:

- Engage community partners in promoting coordinated, quality care, across all provider and community settings
- Offer new funding incentives and flexibility
- Measure delivery system effectiveness and efficiency
- Promote risk-based funding arrangements
- Break down silos in programs and funding
- Think “outside the box” on prevention and health education

Innovations Project Context

- State must implement Medicaid reform law (Public Act 96-1501)
  - Requires 50% Medicaid recipients in "risk-based Care Coordination" by 2015
  - State issued "*Coordinated Care Key Policy Issues*" paper in June 2011 and received 76 responses
- Accountable Care Act is unleashing many CMS initiatives
  - Health Home Demonstration Option for Persons with Chronic Conditions
  - Financial Models to Integrate Care for Medicare-Medicaid recipients (Duals)
  - And many others under consideration

Innovations Project Process

The Innovations Project is designed to achieve the state's goal by:

- Testing community interest and capacity to provide alternative models of delivering care (i.e. not through traditional HMOs)
- Aligning with Accountable Care Act CMS initiatives
- Incorporating feedback from the *Coordinated Care Key Policy Issues* responses
- Building on interagency collaborations

Innovations Project Timeline

- **Phase 1 – Providers Only**
  - Solicitation to be released January 2012
  - Contracts to be executed Summer 2012
- **Phase 2 (a) & (b) – HMOs and Providers**
  - RFP to be released April 2012 for Medicare Advantage
  - Other RFPs to be released Summer 2012
  - Contracts to be executed late Fall 2012

Phase 1 Awards

- Solicitation will be competitive
- No pre-determined number of awards
  - Depends on number of responses
  - Variety of models, proposed populations, and geographical distribution
- 3 year award with possible extensions

Solicitation

- Solicitation will require development of and detailed description of Care Coordination Model
- Will require Letters of Intent from each participating network Provider
- Will require a description of expanded Medical Home functionality within PCP network
- Must address care coordination electronic capabilities
- Proposals may include a limited geographic area
- 3 Year Workplan
- 3 Year Staffing Plan
- 3 Year Budget

Solicitation Support: DATA

- State is working with foundation community to develop a mechanism for providing Medicaid claims data to potential responders for use in Phase 1 solicitation
  - Will provide an equitable, transparent process
  - Ability to query populations, their health use patterns, claims paid
  - Answer unique questions on populations of interest by geography, diagnosis, utilization, etc.
  - Data analytics technical assistance will be available

What is Care Coordination?

Public Act 096-1501, State of Illinois

For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and 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.

http://www.ilga.gov/legislation/publicacts/96/096-1501.htm

What is Care Coordination?

For Innovations Project:

- The role of care coordination is to facilitate the delivery of appropriate health care and other services, and care transitions among providers and community agencies, such as:
  - Among hospitals, primary care and specialists
  - Among hospitals, behavioral health/substance abuse providers and primary care
  - Among existing waiver population care managers and other community agencies and services
  - Among primary care and dental providers

Award Options

Phase 1

Managed Care Community Network (MCCN)

- Flexibility on risk based covered services

Care Coordination Entity (CCE)

- Care Coordination fee
- Shared Savings model or Other Financial Structures
- Medical services FFS

Phase 2

Includes provider sponsored entities from Phase 1 plus:

HMOs

- For expanded populations; full-risk

Medicare Advantage HMOs

- Participate in CMS Financial Models to Integrate Care (DUALS)

Alignment with ACA

- State will submit a State Plan Amendment (SPA) for Section 2703 of the Health Home Demonstration Option for Persons with Chronic Conditions
- State has submitted a Letter of Intent for Financial Models to Integrate Care for Medicare-Medicaid recipients (Duals) for both the Managed Fee-for-Service (FFS) and Capitation options
  - The solicitation will outline how Managed FFS dually eligible individuals may participate in Phase 1 and 2 Care Coordination

Care Coordination: Phase 1

What is a Care Coordination Entity?

- A CCE is a collaboration of providers that develop and implement a Care Coordination model that meets the state's guidelines
- CCE project collaborators must include participation from hospital(s), Primary Care Providers, and mental health and substance abuse providers
- To become a CCE, a group of providers may create a new corporate entity or may contract with the state through a "lead provider"
- A CCE may subcontract with an existing health plan for back office functions

What is a MCCN?

- A Managed Care Community Network is a provider sponsored organization that contracts to provide Medicaid covered services through a risk-based capitation fee
- Is certified by HFS, not Department of Insurance (DOI)
- Must be owned, operated, managed, or governed by providers, state funded medical schools, or county governments
- Has different reserve requirements than HMOs

Phase 1: Common Program Elements MCCN & CCE

Managed Care Community Network (MCCN)	Care Coordination Entity (CCE)
• Flexibility on risk based covered services	• Care Coordination fee • Shared Savings model or Other Financial Structures • Medical services FFS

Enrollment

- Participation in a Care Coordination Entity (CCE) or Managed Care Community Network (MCCN) is voluntary for recipients
- If a recipient elects to enroll, (s)he will be locked into her selected CCE or MCCN for 12 months
- Enrollees may have the opportunity to drop out of a CCE/MCCN with cause at any time, and without cause during the 90 days following enrollment, and at least every 12 months
- Enrollment into CCE or MCCN will be handled by Client Enrollment Broker
- CCE PCPs must be enrolled in IL Health Connect

Priority Populations: Adult

A proposal may serve an unlimited # of recipients, but must serve a minimum of 500, from the priority populations described below:

- Priority populations:
  - Seniors and adults with disabilities (including in long-term care, with serious mental illness, waiver populations)
  - Individuals with Medicare (including duals, LTC)
- Proposal may also serve:
  - Up to an equal number of IL Health Connect adults (not included in the above)
  - Children in the families of enrolled adults
- Integrated Care Program population excluded in Collar Counties
  - ICP population: Seniors and persons with disabilities aged 19 and over, excluding persons with Medicare, and other smaller populations
  - Collar Counties: Suburban Cook, DuPage, Kane, Kankakee, Lake, Will

Priority Population: Children

- A separate solicitation will be released in April 2012 for children with complex medical needs
- HFS is reviewing definitions and service packages for “children with complex medical needs”
- Definition will be detailed in solicitation
- HFS has convened a Work Group to involve stakeholders in the process

More on Priority Populations

- State is particularly interested in proposals that include individuals with mental illness and/or substance use disorders
- Section 2703 of Health Home Demonstration Option targets populations for certain care coordination:
  - Individuals with at least two chronic conditions; or
  - One chronic condition and at-risk for another; or
  - One serious or persistent mental health condition
- Chronic conditions include a mental health condition, substance use disorder, asthma, diabetes, heart disease, and being overweight ; other chronic conditions such as HIV/AIDS will be considered.
- To qualify for this Demonstration Option, proposed Care Coordination model must include services as defined by Section 2703

Quality & Other Performance Measures

- CCE solicitation and MCCN application will contain HEDIS and HEDIS-like performance measures
- In addition, consumer and caregiver satisfaction will be measured
- To the extent similar populations are being covered, state will utilize uniform measures to compare the differing Care Coordination models
- State will hold a future stakeholder meeting to discuss the annual performance and quality goals

Unique Program Elements: CCE

Care Coordination Entity (CCE)

- Care Coordination fee
- Shared Savings model or Other Financial Structures
- Medical services FFS

CCE: Partners

- CCE partners must include participation from hospital(s), Primary Care Providers, and behavioral health and substance abuse providers
- State expectation is CCE partners will expand to include participation of other health care and community based service providers

CCE: Enrollment

- An individual PCP can participate in more than one CCE, but participating patients must select which CCE they want to join (if eligible for more than one CCE)
- All participants will remain in IL Health Connect, if eligible
- If a recipient is enrolled in a HMO or MCCN, the recipient must dis-enroll prior to enrolling in CCE
- Disenrollment and enrollment will be handled by Client Enrollment Broker

CCE: Reimbursement

- CCEs may propose one or more of the following risk based options:
  - Care Coordination Fee
  - Shared Savings Model or
  - Other financial structure
- A portion of the fees from a proposed model must be put into a reserve pool
- Proposal evaluation will include measuring the level of achieved savings - but must be minimally cost neutral over 3 years
- Proposed risk based models must be approved by federal CMS
- Medical Services will remain Fee For Service (as we work towards bundled payments, more capitation and other reimbursement models)

CCE: Care Coordination Fee Structure

- Care Coordination fee paid as Per Member Per Month (PMPM)
- CCEs will propose a Care Coordination fee for each population type to be served, based upon the care coordination model being proposed (Seniors and persons with disabilities, children with complex medical needs, TANF, etc. - to be defined in solicitation);
- Solicitation will provide examples of care management fees currently being paid by State
- CCE must meet performance and quality measures to receive full care coordination fee

CCE: Shared Savings Calculation

- Shared saving calculation will be based on projected cost of care, without care coordination intervention, with negotiated annual cost saving goals
- CCEs will propose how their shared savings will be distributed among the partners (including providers)
- CCEs will be eligible for a percentage of shared savings annually (remaining savings will go to state & federal governments)
- To receive full percentage of shared savings, CCE must meet annual quality and other performance goals
- Shared savings methodology must be approved by federal CMS
- If there are no savings by the end of the contract, the contract will not likely to be renewed

CCE: Other Financial Structures

What are “other financial structures”?

- State encourages proposals to develop new, innovative payment models as long as:
  - Model facilitates care coordination among diverse set of providers
  - Model incentivizes more efficient practice
  - Model meets performance and quality measures
  - Model results in cost neutrality or savings over 3 years
  - Methodology is approved by federal CMS

CCEs: Additional

- State acknowledges providers will need time and resources to build CCE infrastructure; thus, HFS may advance a portion of the Care Coordination fee
- PCPs will continue to receive IL Health Connect care management fee for CCE enrollees
- To support care coordination activities, CCEs may develop electronic capabilities in Year 1 but electronic functionality must be operational 12 months after contract execution
- State goal: CCEs will transition to become MCCNs and take risk for medical services

Unique Program Elements: MCCN

Managed Care Community Network (MCCN)

- Flexibility on risk based covered services

MCCN: Rates and Reimbursement

- At-risk medical services and administrative fees will be included in a capitation rate
- MCCNs may contract with 3rd party for administrative services
- Rates will be specific to the enrolled population by eligibility category, age, gender, and locality
- Rates will be risk-adjusted for health status and other factors, as in current ICP program

CARE COORDINATION: PHASE 2

Phase 2: Medicare Advantage HMO

- State will participate in “CMS Financial Model to Integrate Care Medicare-Medicaid” (Duals)
- RFP to be issued April 2012
- Eligibility may be geographically limited
- 3-way contract with HMO, State, Federal CMS
- Blended Medicare-Medicaid capitation rate for all Medicare and Medicaid covered services
- State must submit applicable waiver/SPA
- HFS will coordinate with CMS, develop RFP, and oversee program

Timeline Summary

- Phase 1 Innovations Project – Providers only
  - January 2012: Solicitation serving adults
  - April 2012: Solicitation serving children

- Phase 2 – Providers and HMOs
  - April 2012: Solicitation serving dual-eligibles
  - Summer 2012: Solicitation for expanded priority populations

Next Steps

- Submit your comments and suggestions in writing by November 1, 2011 to HFS.carecoord@illinois.gov
  - State will post all submissions on HFS website and respond to relevant questions
  - State may incorporate suggestions into the solicitation
- State will hold a future stakeholder meeting to discuss the annual performance and quality goals
- Other stakeholder meetings may be held, as needed, to support state in developing the solicitation

References: Care Coordination and Medical Homes

Agency for Health Care Research & Quality (AHRQ)
http://www.ahrq.gov/qual/careatlas/

NCQA http://www.ncqa.org/tabid/631/Default.aspx

Integrated Care Resource Center
http://www.integratedcareresourcecenter.com

National Quality Forum
http://www.qualityforum.org/Topics/Care_Coordination.aspx

American Academy of Family Physicians
http://www.aafp.org/online/en/home.html

American Academy of Pediatrics
http://www.medicalhomeinfo.org/