

Member Services Toolkit for ACEs and CCEs

Installment #4: What's New about Coordinating Entities, and What's Not

New Approach, Existing Infrastructure

Accountable Care Entities (ACEs) and Care Coordination Entities (CCEs) represent a new approach to service delivery in Illinois' Medicaid program. Patient centered care coordination is the cornerstone of these new models, giving each member the support he or she needs to access the right care at the right time.

While developing new strategies for care coordination, ACEs and CCEs still rely on the existing Medicaid fee-for-service (FFS) reimbursement system for certain functions. The purpose of this toolkit installment is to highlight how ACEs and CCEs represent a change from the FFS system, while also noting how certain aspects of the FFS infrastructure continue to be essential.

What's New

The ACEs and CCEs are truly a departure from business-as-usual in Illinois' Medicaid program. The shift is most evident in three areas:

- ACEs' and CCEs' primary responsibility is to deliver an advanced level of **care coordination** to members. Care coordination fees are intended to seed new and innovative care coordination models, not to underwrite existing staff and services.
- Care coordination is supported in part by the **network** of providers established and cultivated by ACEs and CCEs. Plans should work hard to educate members about the availability and advantages of in-network providers. While ACE and CCE members may still receive care from out-of-network specialists and hospitals, the Department of Healthcare and Family Services (HFS) expects ACEs and CCEs to coordinate care within network as much as possible. If a plan's care coordinators, network providers, or member service representatives learn that a member went out of network for services, they should notify the member's primary care provider (PCP) so the PCP can provide timely follow-up care and record the utilization in the member's chart.
- Innovative care coordination services and well-functioning networks enable ACEs and CCEs to be effective **member advocates**, ensuring easy access to appropriate care and delivering high quality member services. HFS expects that ACEs and CCEs will become trusted resources by focusing on member needs and removing obstacles to care. The ACE and CCE call centers should be able to respond to most member inquiries; referrals to HFS for questions and troubleshooting should be minimal.

What's Not New

The FFS infrastructure continues to support a number of functions:

- Providers are still **reimbursed** on a fee-for-service basis and must bill HFS directly. The current [fee schedule](#) is available on the HFS website.
- **Prior approval** requirements apply to ACE and CCE members as well as clients in the fee for service system. Details about prior approval requirements can be found in HFS' [Provider Handbooks](#).

HFS encourages and expects ACEs and CCEs to act as a front office for their members, navigating these back-end systems on their behalf. Members' HFS-assigned Recipient Identification Numbers and medical cards remain essential tools for coordinating covered services.

Looking Ahead

HFS is committed to achieving an integrated, multi-payer delivery system that rewards high quality care and improves population health. Moving toward value driven care will eventually shift the ACE and CCE payment model away from FFS to value based payment.