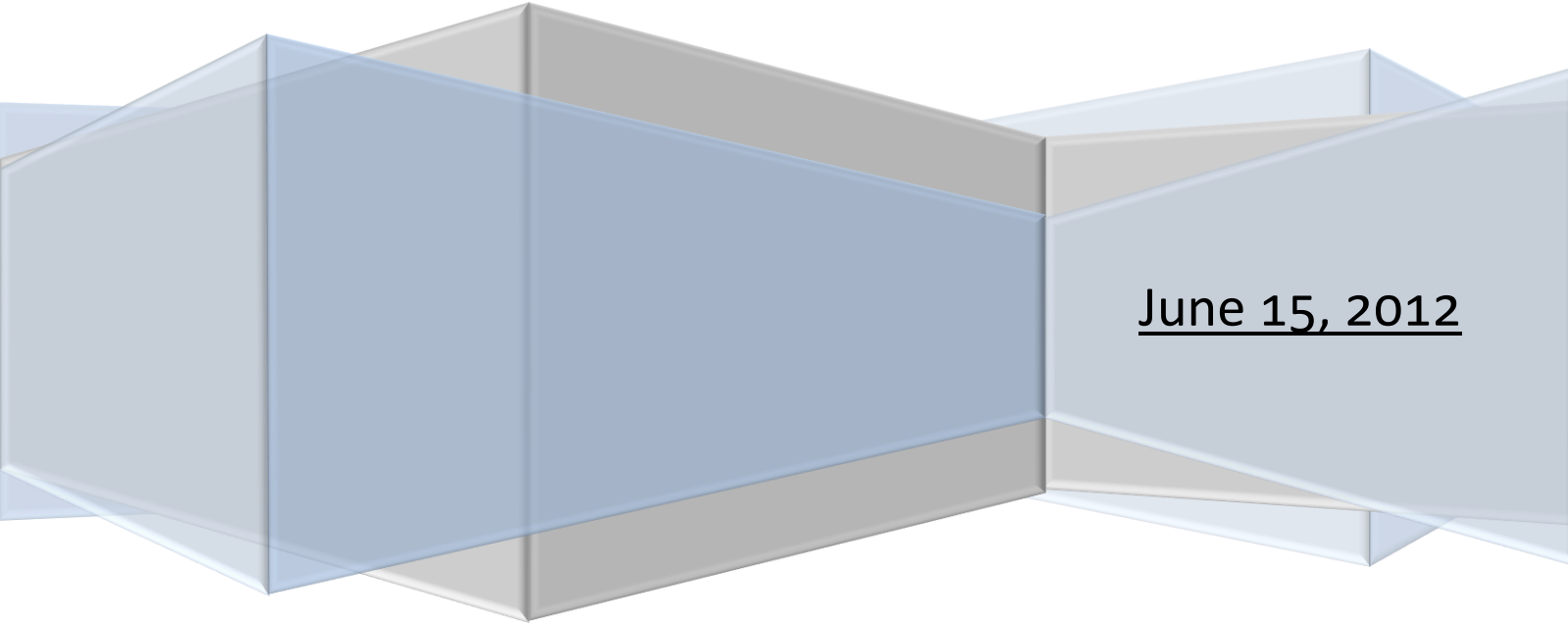


THE HEALTHCARE CONSORTIUM OF ILLINOIS'

PROPOSAL FOR CARE COORDINATION

In Response to the State of Illinois Innovations Project/2013-24-002



June 15, 2012

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3.2 PROPOSAL CONTENTS - EXECUTIVE SUMMARY:

The Healthcare Consortium of Illinois (HCI) is proposing a collaboration (care coordination entity (CCE)) (HCI-CCE) including, but not limited to, primary care and specialty physicians, hospitals, substance abuse providers, community behavioral health providers, and faith-based and community-based organizations – for the purpose of promoting coordinated, quality care for in response to the *State of Illinois Solicitation for Care Coordination Entities and Managed Care Community Networks for Seniors and Adults with Disabilities – Innovations Project/2013-24-002*.

The Priority Population to be served by this Collaboration is Seniors (ages 65 and over) residing in the following thirteen zip codes on the south side of Chicago: 60615, 60617, 60619, 60620, 60621, 60627, 60628, 60633, 60636, 60637, 60643, 60649 and 60653. These zip codes represent all or parts of the following Chicago community areas: Auburn/Gresham, Avalon Park, Calumet Heights, Chatham, Douglas, East Side, Englewood, Grand Boulevard, Hegewisch, Kenwood, Greater Grand Crossing, Hyde Park, Oakland, Pullman, Riverdale, Roseland, South Chicago, South Deering, South Shore, Washington Park, West Englewood, West Pullman, and Woodlawn. The targeted population is Seniors who do not permanently reside within a long-term care facility and require skilled nursing services as their care coordination is the purview of the facility. In addition, HCI-CCE will facilitate care coordination for any eligible family members residing with an enrolled Senior.

HCI-CCE's Care Coordination model is based on a person-centered, assessment-based, interdisciplinary approach that identifies a Senior's required clinical care and non-clinical services and facilitates linkages between all facets of the care and services. At the core of the model is a comprehensive care plan which is managed and monitored by an evidence-based process. Principles in the provision of care coordination are based on adaptations from Rosenberg & Shure's Bridge Model and Boulton's Guided Care Model.

In order to enable effective care coordination, HCI has contracted with Aetna Better Health to implement a broad spectrum of tools facilitating the exchange of health information with collaborators and providers. A variety of HIT tools will be employed to support and enhance the CCE's ability to coordinate care, monitor compliance, provide education and assess quality measures. This will include Aetna Better Health's electronic care management system, case management application, predictive modeling, and consolidated outreach and risk evaluation, Enrollee and provider web-based portal, Active Health Care Engine and Care Considerations.

The proposed remuneration includes tiered Care Coordination fees with a Pay-For-Performance Incentives and shared savings.

3.2.1 GOVERNANCE STRUCTURE, SCOPE OF COLLABORATION AND LEADERSHIP

Name of the Care Coordination Entity

The HCI-CCE is a collaboration (care coordination entity (CCE)) of providers including primary care and specialty physicians, hospitals, substance abuse providers, community behavioral health providers, and faith-based and community-based organizations – for the purpose of promoting coordinated, quality care. HCI-CCE will be paid for care coordination; providers will directly bill the state or federal government for services provided.

Lead Entity- Financial Mechanisms

The Healthcare Consortium of Illinois (HCI) will be the lead entity of HCI-CCE.

HCI is a community-based, membership-driven, non-profit organization whose roots are based in collaboration. Established in 1991 (as the Southside Health Consortium), its initial collaborators were four hospitals which came together to respond to what was increasingly viewed as a fragmented, duplicative and inefficient healthcare system serving the largely, minority, impoverished community areas of the southern regions of the metro-Chicago area. Its goal was to establish a network of physicians and community-based organizations.

Today, HCI's membership consists of 37 diverse organizations representing all facets of health and human services. Its mission is "to improve the health of families through the development of comprehensive, integrated health and human services". HCI brings its mission to fruition by being a "network of networks" which provides a full range of health and social services from birth to death through its membership organizations. Programs which HCI currently directly implements or oversees implementation of include the HealthyStart Southeast Chicago Program which provides health and social support to pregnant women and their newborns; the Family Case Management Program which serves pregnant women, infants, and children with high-risk medical conditions; the Workforce Development Program which assists adults with educational, vocational and employment training leading to productive career paths; and the Senior Care Programs (Comprehensive Care Coordination, Flexible Senior Services, Elder Abuse & Neglect, Money Follows the Person) which provides myriad case management services to allow people over 60 to remain or transition back to an independent, safe and healthy home environment. HCI also has a variety of disease-specific projects, as well as faith-based initiatives which augment its programs.

HCI has a strong financial infrastructure in place currently servicing ~\$11M in federal and state-funded programs and initiatives; it has one of the largest service contracts with the Illinois Department of Aging. With this responsibility, it has well-established mechanisms for payroll, human resources, quality assurance and service delivery, and as a federal and state grant recipient, it has undergone and passed rigorous annual financial audits. With a 20+ year,

successful track record in being a lead agency creating and implementing systems of healthcare, HCI is uniquely positioned to be the lead entity and to meet the goals and requirements as outlined in the Solicitation.

Collaborators & Their Community Experience

Initial key collaborators in the HCI-CCE include four hospitals - The University of Chicago Medicine, Roseland Community Hospital, St. Bernard Hospital and Health Center, and South Shore Hospital. These hospitals provide a wide array of services – many available on a 24/7 basis - and are geographically dispersed throughout the covered communities to minimize Enrollees’ distance barriers in accessing care. Additional initial key collaborators include the Human Resources Development Institute (HRDI) who will lead in the development of mental health and substance abuse network and Comprehensive Quality Care who will lead in the coordination of healthcare services in the home network. Primary Care Physicians may be provided by Beloved Community Family Wellness Center or in home with Home Health Medical, LLC and Associates. A complete listing of initial collaborators is attached (*Attachment E*).

The initial key collaborators were chosen based on their locations to provide the broadest coverage in the geographic area, their scope of services and experience in currently serving the medical, behavioral and social needs of the intended population, and their financial stability so that HCI-CCE cannot only enroll, but also retain, the largest number of eligible Seniors in care coordination. In addition, many of the key collaborators are also members of the Healthcare Consortium of Illinois and have representatives which sit on the Board of Directors.

Located in Hyde Park (on 58th street between the Dan Ryan Expressway and Lakeshore Drive), the University of Chicago Medicine (U of C) medical campus includes Comer Children’s Hospital, Bernard A. Mitchell Hospital for adult inpatient care, Chicago Lying-in Hospital, and the Duchossois Center for Advanced Medicine and is a world-renowned provider of specialty and sub-specialty medical care. U of C also has outpatient locations throughout the Chicago area. U of C physicians are members of the University of Chicago Physicians Group, which includes more than 700 physicians and covers the full array of medical and surgical specialties and subspecialties. Committed to improving health and access to quality care for the South Side of Chicago through patient care, community-based research and medical education, U of C has established the Urban Health Initiative. Integral in the Urban Health Initiative is its Southside Healthcare Collaborative, an affiliation of over thirty community health centers providing affordable primary care services in the geographic area.

Roseland Community Hospital (RCH) is located on 111th Street equidistant between I-57 and the Bishop Ford Freeway and has been serving the community over approximately 90 years. As a 162-licensed, bed acute care facility, the hospital provides a variety of inpatient, outpatient and

emergency room family and individual services. In 2009, RCH opened a state-of-the-art emergency room which averages over 23,000 visits annually. In 2011, RCH opened the only Inpatient Adolescent Behavioral Health Unit on the South side. In August 2011, RCH became a medical district - one of only two in Chicago. The hospital is declared a safety net hospital by CMS because of its high volume of Medicaid/Medicare and being the only hospital in a seven mile radius.

St. Bernard Hospital and Health Center has been providing quality health care for the Englewood and surrounding communities for over 100 years. St. Bernard offers medical care at its campus, which includes the 220- bed hospital, emergency room and the Professional Pavilion. There are also physician offices located throughout the community. In 2011, St. Bernard was awarded HealthGrades Emergency Medicine Excellence Award ranking it among the top 5% in the country. Their cardiac care, pulmonary care and critical care programs have achieved national recognition. But their mission is not only vested in excellence in medical care, St. Bernard is also committed to the community's economic health. In collaboration with the City of Chicago and the Chicago Neighborhoods Initiatives, they built a 70-unit affordable housing development near the hospital to revitalize the community. They are also one the founders of Teamwork Englewood which runs a New Communities program to improve quality-of-life issues that local residents determine are most important to the community. Located on 64th Street and the Dan Ryan Expressway, it is Englewood's largest employer.

South Shore Hospital is an acute care, 170-bed facility with a full range of services that has been meeting the healthcare needs of the community for 100 years. Located east of the Chicago Skyway on 79th Street, it has been known for delivering quality medical care for the whole family while managing costs. It provides complete primary care services at its five affiliated neighborhood clinics and through its affiliated physicians. Through its Senior Complete Care Center, it is able to be a comprehensive resource for people who are 55 and older, offering an inter-disciplinary patient care approach by specialists in geriatric medicine, nursing, social work and nutrition.

HRDI, a national company based in Chicago, provides services in alcohol and substance abuse prevention and treatment, mental health, youth prevention, family services, community health, case management, alternative youth education, HIV/AIDS prevention and education, corrective services, and gambling prevention and education.

Comprehensive Quality Care is a home health care agency offering the full complement of in-home healthcare services, including, skilled and psychiatric nursing, physical and speech therapy, disease management, medical social work, and home health aides. Established in 2001, it has gained a reputation in the community as a provider of professional, quality services, recently opening a second office to meet the needs of its expanding service area.

Primary Care Physicians collaborators include the FQHC, Beloved Community Family Wellness Centers (BCFWC) located in the greater Englewood community and Home Health Medical, LLC and Associates. BCFWC provides medical services to people of all ages as well as a complete complement of support services. Home Health Medical is a physician-based organization providing in-home health services including physician services, skilled nursing and therapies, as well as extensive diagnostic testing.

Aetna Better Health Inc. has been selected to assist HCI-CCE through a sub-contractor relationship for back-office and HIT functions. Together with its affiliates, Aetna Better Health, Inc. has collectively provided Medicaid Enrollees across the nation with access to health care coverage for more than 20 years. It currently owns or manages the aged and disabled and special needs populations, TANF, and SCHIP benefits for more than 1.3 million Enrollees in nine states providing comprehensive care management services for more than 277,000 aged and disabled health plan Enrollees and another 16,000 dually-eligible (Medicare and Medicaid) individuals through its Medicare Advantage Special Needs Plans. While HCI-CCE is dedicated to serving the Senior population who does not wish to participate in a full-risk capitation model, should state contractual requirements necessitate a change in the model, the relationship with Aetna Better Health provides a platform for a seamless transition.

Scope of Collaboration based on Claims Analysis

According to the Chicago Health & Chicago Health Systems Project which was commissioned by the Chicago Department of Public Health, the total population of the 13 zip code area to be serviced by HCI-CCE is 656,181. The racial composition of the entire geographic area is 84% Black, 6% Hispanic and 2% Asian. Over 41% of this population (272,525) received Medicaid services. Medicaid expenditures for the entire population during 2010 were \$1,082,383,314. These expenditures are further delineated by age grouping below:

<u>Age Group</u>	<u>Total Recipients</u>	<u>Total \$\$</u>	<u>\$\$/Recipient</u>
Less Than 1 year	8,153	\$ 70,327,017	\$8,626
Ages 1-18	142,027	\$ 201,580,846	\$ 1,419
Ages 19-20	10,541	\$ 23,659,223	\$ 2,244
Ages 21-44	61,120	\$ 265,293,060	\$ 4,341
Ages 44-64	33,303	\$ 377,084,372	\$11,323
Ages 65 & older	<u>17,381</u>	<u>\$ 144,439,797</u>	\$ 8,310
	272,525	\$1,082,384,314	

A further analysis of the population indicates there is over 76,000 Seniors (65+ years) in this service area. Approximately half (36,213) are, at a minimum, two times below the poverty index. However, according to claims data that was provided by the State, only 17,381 Seniors were enrolled in and/or received Medicaid services during 2010. Of these enrollees, 15,947 were dual-eligible. Senior Medicaid expenditures delineated by eligibility are listed below:

<u>65 & Older</u>	<u>Dual</u>	<u>Non-Dual</u>	<u>TOTAL</u>
# of Enrollees	15,947	1,434	17,381
Total \$\$	\$125,628,647	\$18,811,149	\$144,439,797
\$\$/Enrollee	\$ 7,878	\$ 13,118	\$ 8,310

In a January, 2011 Center for Medicare Advocacy *Weekly Alert* concerning Medicare Advantage enrollment, CMS indicated that enrollment in these types of plans was up to 15% (from 3% in the 1990’s); however, because most potential enrollees are eligible for a full array of services offered by their respective state’s Medicaid plan – including services not offered by Medicare – there is no perceived value in being in Medicare Advantage. Data provided by the state in preparation for the Innovations Project supports this finding as it has only approximately 1% of dual-eligible recipients in the proposed geographic area enrolled in a Medicare managed care product.

There are several challenges which present themselves when trying to build a collaborator/provider network to coordinate care for HCI-CCE’s intended population. The major intrinsic challenge faced by any CCE whose targeted population is Seniors, most of whom (~92%) are dual-eligible and have an option to remain in a fee-for-service arrangement, is to have capacity and choice so that Seniors do not perceive that they have to sever their established provider relationships to have their care coordinated. According to the provider data supplied in Data Set I, the totality of Medicaid recipients (272,000) sought care from over 12,000 physicians (~9,000 in Cook County) and approximately 300 hospitals in 85 of Illinois’ 102 counties and 35 states other than Illinois. It is reasonable to infer that Seniors seek care from a combination of providers who tend not to be exclusively in one system, crossing between hospital systems, provider networks, and non-traditional providers. Because of the variability in location and type of providers, there is no standard electronic communication platform to share patient information effectively.

Because of HCI’s experience in the proposed communities, this challenge was anticipated and key collaborators were chosen accordingly. The key hospital collaborators provided ~60% of the inpatient and emergency care for all recipients based on events and/or units of service. In keeping with its proven model of promoting “networks within networks”, HCI-CCE will build off its existing relationships with the key hospitals and utilize physicians on their staffs as its base

of primary care and specialty physicians. This approach provides access to over 1,000 providers covering all primary care and medical specialties and subspecialties, and support services including dentistry – many of which are medical homes and can manage co-morbid chronic health conditions. In addition, as Seniors choose HCI-CCE, if it is found that their providers are not part of the HCI-CCE network, their providers will be contacted and have a choice to join the network or participate as single-case user.

HCI-CCE also recognizes that many of the targeted Seniors will reside in multi-generational homes, and all persons in a home affect a Senior's health outcome. With HCI as the lead collaborator, HCI-CCE has a unique collection of programs that it can refer family members to should it be required. In addition, traditional managed care methods utilized to direct a Senior's care (e.g., prior authorization, use of restricted provider networks, formulary management, etc.) cannot be mandated as payment for provider services will be made directly from the state or federal government rather than HCI-CCE. A Senior's participation in care coordination, as well as any health improvement strategies, will be incumbent upon maintaining relationships with the Seniors and their caregivers– something HCI has been doing for almost twenty years.

Lastly, one of the principal ramifications of choice is the lack of a standard EHR platform to share information contemporaneously to facilitate timely care coordination. Through its agreement with Aetna Better Health, HCI-CCE will be able to provide an innovative approach to coordinated care through an electronic, individualized care plan for each Senior that can be shared with all of the Senior's providers, regardless of their hospital affiliation, location, or status of electronic record implementation, via a secure, web-based portal.

While the State's data supports HCI-CCE's assessment of the challenges, there are limitations in how the data can be utilized. The data provided does not delineate a definitive linkage for a recipient (or even age-group of recipients) and specific providers. It is also based on 2010 claims data and does not provide time/residence specific linkages for a recipient and his/her provider (e.g, a recipient may have lived in North Cook County and sought care from local providers but has subsequently moved to HCI-CCE's geographic area and now may or may not be seeking care from local providers). The data also does not allow for analysis of multiple eligible recipients within a same residence.

Realizing the population has changed from the time that the State's data was collated - and will continue to change- as well as the above mentioned limitations, analysis of the collaborator/provider network will need to be an ongoing process to ensure that it has the capacity to meet the needs of the intended population. To this end, HCI has obtained the permission of the Illinois Department of Aging (IDoA) to poll HCI's ~16,000 Senior Care Program

clients as to their providers. This will provide a more accurate, complete snapshot of the intended population's currently utilized providers.

The composition of the key collaborators and/or providers will continually be re-assessed to ensure they provide not only quality and cost-effective care, but also represent the choice of the intended Senior population. Additional collaborators and/or providers will be considered for inclusion in HCI-CCE based on the outcome of the poll, Senior forums and network re-assessments.

Governance Structure

HCI-CCE will be an operating sub-unit of the Healthcare Consortium of Illinois, an Illinois not-for profit organization (*Attachment G – Articles of Incorporation*). It will be accountable to the HCI Board of Directors and subject to HCI existing operating policies and procedures, as well as requirements imposed by other HCI federal and state grants and programs. The HCI Board of Directors is comprised of individuals from its member organizations who have been nominated, vetted, and elected to the Board. A Board member may serve a pre-determined one, two or three year term. HCI Board leadership is nominated and elected by members of the Board.

In addition, HCI-CCE will report to the Collaborator Council which will have representation from the key collaborators as well as representation from the targeted Senior population and the community at-large. The Collaborator Council will be an advisory council providing input on the care coordination model, reserve utilization, provider issues, and operating policies.

HCI-CCE will be led by a full-time Executive Director. This position will have a direct dual-reporting relationship to both the HCI CEO and the HCI-CCE Collaborator Council. Reporting to the Executive Director, the HCI-CCE Management Team will be organized functionally by Care Management, Business Planning & Operations, & External Affairs. In addition, Legal and the Medical Director will report to the Executive Director.

Care Management will be led by the Director, Care Management. This position will oversee Care Managers and Patient Navigators, as well as the Call Center. This position will also have an indirect reporting relationship to the HCI-CCE Medical Director. The Director of Business Planning and Operations will be responsible for day-to-day activities related to finance, information technology and human resources. Credentialing will be a function of human resources. The Director of External Affairs will be the primary internal and external communications representative for HCI-CCE and oversee all communications functions including network development, marketing, Senior relations, and community relations and outreach.

Initially, some of these functions may be provided through contractual relationships to allow for unpredictability in enrollment patterns. Providing some staffing through reallocation of existing HCI staff will also allow for flexibility and immediacy in filling budgeted part-time positions. A complete staffing plan, key job descriptions and organizational chart are also included in *Attachment G*. Financial ramifications are delineated in the three year budget in *Attachment H*.

Consumer Input

In addition to having representation on the Collaborator Council (see above), Senior Enrollees, as well as others from the community will be invited to participate in regularly scheduled community forums. HCI-CCE will conduct these forums to identify gaps, not only in providers/collaborators, but also services. These forums will also elicit information from Senior's regarding the efficacy of outreach and external communication efforts. This is an activity that HCI regularly conducts for its other current programs. In addition, Seniors and members of the community will be invited to HCI's monthly General Assembly meeting. This meeting features a variety of speakers who provide health-related policy updates and seek feedback from the community.

Key Leaders

Salim Al Nurridin is the Chief Executive Officer of the Healthcare Consortium of Illinois, a position he has held for almost twenty years. Under his direction, what began as a concept and a mission for care coordination and integrated service delivery by HCI and its members has produced Health Works of Cook County, Advanced Behavioral Care Network, the Southeast Chicago Healthy Start Initiative, and the Senior Care Program services which supported the vision for an improved quality of life for all Illinois residents to become a reality. His ability to facilitate bringing a vision to fruition is rooted in his early experiences as a Program Director for Families with a Futures/Healthy Moms-Healthy Kids, Youth Development Coordinator for the City of Chicago, Model Cities program, and a U.S. National Student Association Field Organizer. Mr. Al Nurridin is also active with many state and civic organizations.

The Executive Director of HCI-CCE will be Louanner Peters. Ms. Peters is a well-known public policy expert in state government and national political circles, and she brings a wealth of leadership to HCI-CCE. Ms. Peters holds a Bachelor's degree in Political Science from Louisiana State University and Master's degree in Social Work from the Jane Addams College of Social Work at the University of Illinois-Chicago. She is also a Fellow of the National Institute of Mental Health. Early in her career, she was the Executive Director of the Flannery Senior Healthcare Center. Ms. Peters served as deputy governor in the Office of the Governor where she provided oversight and supervision for the Illinois' Health and Social Services, Public Safety, Natural Resources, Historic Preservation and Capitol Development agencies in the areas of

policy and program consistency and fiscal management. Previously, Ms. Peters directed district offices for two members of Congress, both from the proposed geographic area, with over ten years on Capitol Hill. She also worked at the national office of the National Association for the Advancement of Colored People (NAACP) on their Voter Empowerment Project. For over three decades, Ms. Peters has built an impressive resume of activism, public policy, political advocacy and fiscal management.

Ronald Sam, D.O., will be the HCI-CCE Medical Director. Dr. Sam is a practicing internist with over fifteen years of experience in the private practice, community setting. In addition, he has over twelve years of experience in providing a full-service, physician-based in-home health care to elderly and disabled patients. His vision to provide coordinated care for the elderly, home-bound and disabled patients began as he went through his residency at Cook County Hospital. There he focused on emergency medicine, intensive care medicine, patient education, medical economics, clinical decision making and patient safety. His vision was further refined from personal experience as he became the primary care coordinator for his elderly parents managing the difficulties associated with transportation to testing and provider appointments on sequential days, as well the lack of a central resources. Dr. Sam is active in community and public service participating in the Urban Healthcare Initiative: National Rainbow Push Convention as a facilitator of healthcare workshops, collaborating with the Illinois Institute of Technology on mentoring youth interested in healthcare and science careers, and working as a Preventive Healthcare Counselor at St. Martin De Porres House of Hope providing medical care to individuals residing in the temporary shelter.

The HCI-CCE Director of Care Management will be Joanne Glenn, R.N. Ms. Glenn's professional nursing career started after she graduated from Michael Reese School of Nursing in 1973. For the next ten years she worked in home health, nursing home, and hospital settings providing hands-on nursing care as well as holding a variety of supervisory and management positions as well. She then expanded her career to encompass managed care - working as a Clinical Program Specialist, Triage Nurse, and an Educator for Michael Reese Health Plan – positions she held over the next nine years. Intrigued with the law and medicine, Ms. Glenn attended Roosevelt University completing a paralegal program, and started Glenn-Gavin Medical Legal Consultants. During this time she also earned her B.S. in Management and Education. She concurrently co-founded Comprehensive Quality Care, Inc. Foundation where she is Chief Operating Officer and Director of Patient Services where she oversees clinical aspects of home health skilled & psychiatric nursing, speech and physical therapy, medical social workers and home health aides. Ms. Glenn is published in research, A National Peer Reviewer for Prevent Child Abuse America and a Fellow of the Illinois Maternal Child Health Institute. Collaboration, team-building and networking are her forte.

Mayme Buckley will be the Director of External Affairs which is responsible for all external communication and outreach, provider network development and relations, and Senior relations. She is well-suited for this position as she brings extensive experience working with HCI in a variety of positions including Director of Faith-based initiatives and Director of Provider Relations for the Healthworks program. She has also been responsible for managing educational program for children and adults in the areas of asthma, obesity and HIV awareness. She is civically active in the area serving on the Advisory Council for the Center for Faith and Community Transformation which is a collaboration of partners from the University of Illinois, Advocate Health Care and the Cook County Department of Public Health. She also serves as a Commissioner of Housing and Human Relations for the Village of Matteson, Illinois.

3.2.2 POPULATIONS/GEOGRAPHY

Priority Population to be Served

The Priority population to be served by HCI-CCE is Seniors (ages 65 and over).

Geographical Area to be Served

HCI-CCE will provide Care Coordination Services to Seniors residing in the following thirteen zip codes on the south side of Chicago: 60615, 60617, 60619, 60620, 60621, 60627, 60628, 60633, 60636, 60637, 60643, 60649 and 60653. These zip codes represent all or parts of the following Chicago community areas: Auburn/Gresham, Avalon Park, Calumet Heights, Chatham, Douglas, East Side, Englewood, Grand Boulevard, Hegewisch, Kenwood, Greater Grand Crossing, Hyde Park, Oakland, Pullman, Riverdale, Roseland, South Chicago, South Deering, South Shore, Washington Park, West Englewood, West Pullman, and Woodlawn.

The methodology in choosing the geographic area was in alignment with the care coordination service area HCI services through its Illinois Department of Aging (IDoA) Care Coordination contract. By coinciding service areas, this allows for the assessing and honing the continuum of the care coordination model to include not only supportive care coordination, but also clinical coordination, in an area where providers and support resources are well-known to HCI-CCE. Once established, HCI-CCE would consider expanding implementation of its care coordination model to a larger geographic service area if it meets the needs of the State.

Targeted & Non-Priority Populations

HCI-CCE's target population will be Seniors in the community and Persons who are Elderly receiving Home & Community-Based Services (HCBS) including Dual-eligible Seniors who dis-enroll or opt out of a MCO plan under the Medicaid-Medicare Dual Alignment Project (Phase 2 of Innovations Project). HCI-CCE recognizes that some Senior's health status acuity may predispose them to being better served by an MCO's clinical care program. Through its outreach efforts, HCI-CCE will work with the Senior population to help them make informed care coordination choices that best suit their clinical, psychological, and social needs.

Subsequent to release of this Phase 1 Solicitation, the State determined that dual-eligible Seniors will initially be passively enrolled into MCO's (with an option to enroll or dis-enroll at any time) under Phase 2 of the Innovations Project which runs concurrently with this proposal. As noted in the Scope of Collaboration section, the national participation by Seniors in Medicare managed care is only 15%. Combininf this with the proposed geographic area's negative perspective of managed care caused by to previous experiences, it is conservatively anticipated that over half of the dual-eligible population will either not enroll or opt out of an MCO over the term of the contract. This would results in the State potentially having ~\$70

million dollars in uncoordinated care. (Due to recent changes in the State’s Medicaid services in response to budget mandates, some Seniors who may have previously been refractory to managed care options may consider participation depending on the plan’s features; hence, the projection of ~50% participation rate for MCO’s rather than only 15%.) Seniors (both dual-eligible and non-dual-eligible) represent the State’s third highest Medicaid utilization population based on average dollars spent per enrollee. In order to facilitate the provision of quality care that is cost-effective for all Seniors - not only those enrolled in an MCO - it is fiscally prudent for the State to offer a CCE option for this population.

HCI-CCE does not contemplate serving any non-Priority populations. However, as previously noted, all persons living with a Senior affect their health status; therefore, it is incumbent upon HCI-CCE to offer to facilitate care coordination to other care coordination programs for all eligible persons residing with an enrolled Senior. HCI’s vast knowledge of health care services and programs existing in the service area will ease the process of any referral.

Phase-in Enrollment Targets

Because CCE enrollment is voluntary, the inclusion of passive auto-enrollment into an MCO in Phase 2, and the analysis of claims data, HCI-CCE’s has revised its enrollment from its LOI projection to now target to enroll 5,000 Seniors during the initial term of the contract. Enrollment in HCI-CCE will take a graduated approach as delineated below:

	<u>Dual-eligible</u>	<u>Non-Dual-eligible</u>	<u>Total</u>
Year 1	600	400	1,000
Year 2	2,000	500	2,500
Year 3	4,000	1,000	5,000

Owing to HCI’s documented outreach in the community for the past twenty years, HCI-CCE is conservatively estimating that it will enroll approximately half of the dual-eligible Seniors who do not participate in a MCO and two-thirds of the Seniors who are non-dual eligible in the geographic area by the end of the three year contract. By targeting enrollment at only 1,000 Seniors in Year 1, this will allow an adequate sample to initially test the care coordination model systems and processes. Testing of the model during the first year is critical to gather real implementation data, assess strengths and weaknesses, and implement improvement strategies prior to expanding enrollment. The attached draft implementation work plan (*Attachment H*) further delineates timetables associated with operationalizing HCI-CCE. Financial implications of the phased-in enrollment are included in the three year budget (*Attachment I*).

3.2.3 CARE COORDINATION MODEL

Need for Care Coordination

It is well-documented that the current state of the healthcare provision across the continuum is fragmented with negative health status outcomes and significant financial implications. Lack of coordination promotes duplication of both professional and ancillary services and fosters delays in care which leads to care being provided in more costly settings. Outcomes of disjointed care are even greater for vulnerable populations such as the low-income, elderly, and minorities.

Reimbursement for these populations is often exclusively the purview of government (either state or federal) payers. These payers' disease management programs (e.g., congestive heart failure, nosocomial infections, etc.) are traditionally provider-centric rather than patient-centric. Utilization programs have a financial management focus to curb utilization unless direly ill. Behavioral health needs are traditionally addressed only at their most extreme manifestations, if at all. The culmination of these actions reinforces Seniors' contact with healthcare being episodic and often through an Emergency Department as an initial point of care provision – an observation validated based on HCl's experience in its Senior Care programs.

In addition, clinical and non-clinical care services that are socio-culturally competent are rare, which hinders not only communication between patients and their providers, but also the patient's transition between providers and phases of care. The norm is for the provision of care to end at close of service (visit, discharge, etc), and coordinated follow-up care via a provider or a payer tends to be exclusively telephone-based (often not in the same state) if at. It is also socio-culturally lacking which further promotes fragmentation. Lastly, physical, emotional and informational support may come from, not only family, but friends and others in their community which are traditionally not included in the planning or facilitation of their care. This system reinforces passive participation in healthcare at its most expensive provision.

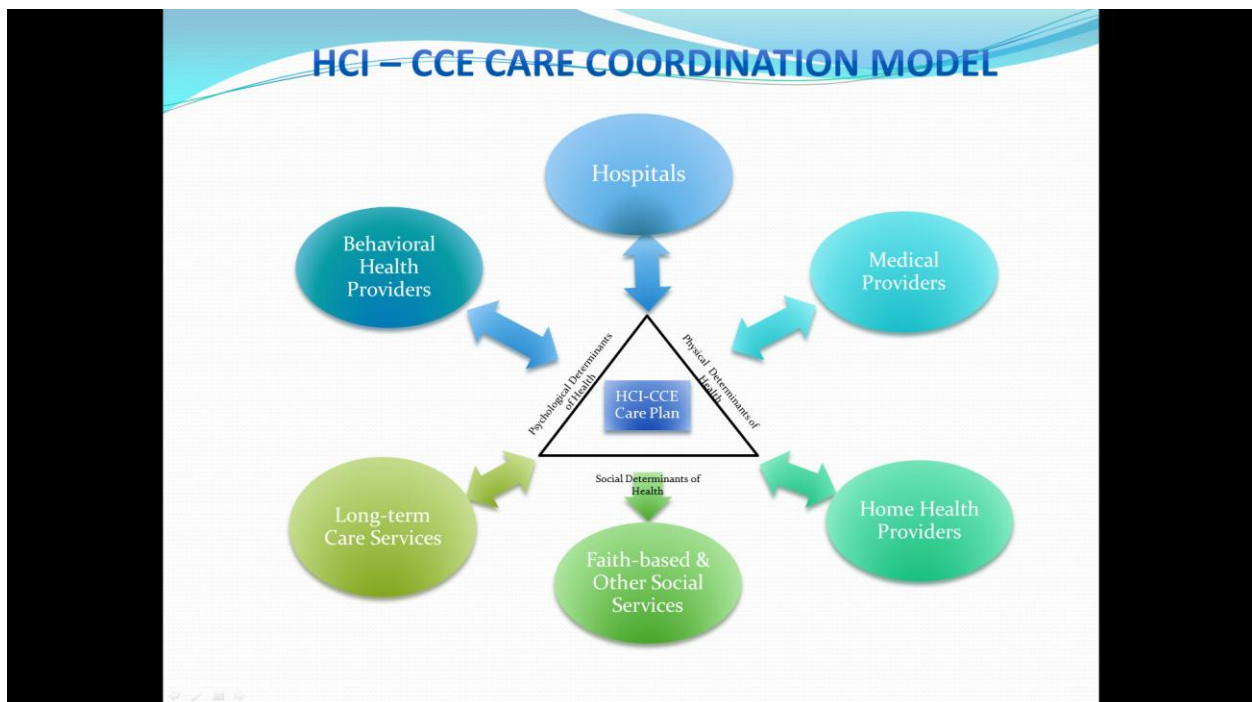
Recent changes in reimbursement are forcing providers to re-examine their role in the continuity of care. Never events ('errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients'), which have an increasing probability with the number of days a patient is hospitalized, can cause denial of complete reimbursement. Hospital admissions, previously an unfettered revenue source via volume or length of stay (depending upon payer), now have non-payment consequences for the hospital if a patient is re-admitted in thirty days (regardless of re-admitting hospital). Discharge planning can no longer end at the confines of the building.

Physicians and other providers, while still predominantly paid on a per-service basis, are also being tasked with implementing and meeting quality mandates with decreased reimbursement rates. With no national health information system, communication between providers is problematic and time-consuming, often needing to share the same information with multiple providers. This promotes, at best, a delay in sharing critical information, and at worst, a complete breakdown in communication leading to delays in care, duplication of services, and ultimately higher costs. While reimbursement may be forcing a paradigm shift from competition to collaboration, mechanisms to support the shift are almost non-existent – particularly for providers and services that participate in multiple healthcare system networks.

Approach to Care Coordination

HCI-CCE’s care coordination approach was developed to meet the needs addressed above.

HCI-CCE’s care coordination model is based on a person-centered, assessment-based, interdisciplinary (PAI) approach that identifies a Senior’s required clinical care and non-clinical services and facilitates linkages between all facets of the care and services. At the core of the model is a comprehensive care plan which is managed and monitored by evidence-based processes. Principles in the provision of care coordination are based on adaptations from Rosenberg & Shure’s Bridge Model and Boulton’s Guided Care Model. The focus will be to move from “disease focus” to a “person focus”. The HCI-CCE care coordination model addresses the inter-relational aspects of physical, psychological, and social determinants on a Senior’s health status.



While many models incorporate variations of these care coordination philosophies, HCI-CCE's care coordination model includes two innovative components:

1. bringing care coordination to the Senior's home through the use of Patient Navigators and in-home medical services, if required; and
2. linking all providers to the individualized Senior care plan via a secure, web-portal.

Patient Navigators are community-based healthcare workers who will provide the daily connectivity (if needed) between Senior and HCI-CCE. They will observe Seniors in their homes so as to accurately assess the many social factors affecting Seniors' medical and psychological health, and their ability or inability to meet care plan goals and objectives. For example, many providers furnish patient education concerning the need for diet modification; however, a Senior may not be able to translate that to appropriate food choices. By visiting a Senior in their home, a Patient Navigator will be able to assess the food currently in the Senior's home, as well as discuss the Senior's specific eating habits, preferences, food preparation capabilities and current food purchasing mechanisms specific to the community. With that level of information, the Patient Navigator, working with their assigned Care Manager, can tailor the care plan with specific, achievable outcomes with targeted services to help meet the goal. Patient Navigators will be the physical representation of the HCI-CCE model in the community becoming the anchor in building and maintaining trust with Seniors.

The use of a web-based, comprehensive care plan provides a vehicle where goals and outcomes related to all aspects of the Senior's health can be documented and shared between providers regardless of the electronic health record that they may utilize. This sharing of information as a Senior transitions care between inpatient and outpatient providers as well as primary care and specialty providers, mental health providers, and substance abuse providers will not only enhance the likelihood of Senior's having a positive health status, it will also facilitate appropriate provider, ancillary service and prescription utilization. While primary care providers are being tasked with greater care coordination responsibility (via a medical home or health home), few have the time or training to monitor and coordinate Seniors with concomitant medical, psychological and/or social issues. The HCI-CCE care model with its innovations supports the involvement of the PCP relationship in care coordination by bridging communication gaps.

The model is based from the Senior's frame of reference and educates from Senior's perspective rather than educating from the providers perspective. By actively engaging Seniors regarding factors (susceptibility, severity, benefits, barriers, self-efficacy) affecting their healthcare, as well as more accurately assessing the modifying factors that exist in their specific

realms, the likelihood of behavioral change occurring and sustaining increases dramatically. The addition of these innovations will promote Seniors making positive health changes a reality.

Success in engaging and retaining Seniors in active, participant-directed care coordination which promotes not only appropriate utilization, but also disease prevention, will be predicated on whether trust can be established in the care coordination relationship. A basic tenet in building that trust will be a Senior's perception that their care coordination is reflective of their individual needs incorporating their local community. Trust will be fostered by Seniors establishing a relationship with both Care Managers and Patient Navigators.

Seniors will affirmatively enroll in HCI-CCE. If the initial contact is made directly to HCI-CCE, a Patient Navigator will refer the Senior to the Illinois Client Enrollment entity for eligibility determination and enrollment. HCI-CCE may also be notified of a new Senior's enrollment indirectly through its monthly monitoring of claims data from the State which will be flagged for new enrollees. Upon verification of enrollment, a Care Manager will contact each Senior to begin building a relationship with them, as well as their caregivers. Contact will be made no later than 30 days following enrollment verification; sooner if by request or if analysis of the claims data warrants it. Motivational interviewing skills will be utilized to elicit key information from the Senior and their caregivers. A Patient Navigator will conduct a follow-up home visit to assess a Senior and their caregivers in the Senior's environment and document the social factors impacting health and care. Trust will gradually be built through the continued personal interaction with the Patient Navigator.

During the initial contact, the Care Manager will coordinate a comprehensive medical assessment of the Senior with their primary care physician (PCP) if the Senior hasn't had one within the previous ninety days. If a Senior does not have an established primary care relationship, the Care Manager will provide the Senior choices of HCI-CCE's preferred PCP/medical home providers. If the Senior has had a recent assessment, the Care Manager will determine if the physician is a preferred HCI-CCE provider and engage the physician, or his/her designee, in the assessment process. If the physician is not a preferred provider, Network Development personnel will contact the provider for inclusion in the network. A Senior who is unable to leave their home will have an option for an in-home medical assessment which eliminates the cost of non-emergency transportation. Working with the PCP, referrals to medical specialty care will be facilitated, as needed, based on the assessment.

Because it is estimated that 30% of the population suffers with mental health and/or substance abuse issues, (many of them being undiagnosed, under-diagnosed and/or co-occurring), the Care Manager and/or Patient Navigator will also conduct a mental health and alcohol and substance abuse screening with every enrolling Senior. It is anticipated that many of the Seniors may have sensitivity to the screening questions via the telephone, and the assessment

may be best conducted in a face-to-face interaction. Based on the screening outcome, a Senior will be directed to an appropriate provider for further assessment and follow-up care. The culmination of this medical, social and psychological outcome data will be the development of an individualized Care Plan.

HCI-CCE Care Managers and Patient Navigators will work as a team in coordinating a Senior's care. Care Managers will include licensed workers (either registered nurses or clinical social workers) who will and work with PCP's, specialists, hospital and other providers overseeing the coordination of the clinical aspects of a Senior's care as well as all aspects of care coordination. Non-clinical responsibilities, such as community resource coordination, may be assigned to Patient Navigators. Patient Navigators specialized knowledge and training of community resources will allow them to facilitate linking appropriate support services with Seniors' identified care gaps. A majority of a Senior's care team members will reside in the communities that they serve which facilitates cultural sensitivity as well as fosters the trust and awareness that the care team understands their community which is essential for success.

The initial assessment will also determine a Senior's initial care coordination tier. For care coordination, Seniors will be stratified into tiers based on their complexity, severity and utilization:

Tier 1 (Intensive Care Coordination)- will include Seniors who have complex primary and/or secondary chronic conditions, mental illness, addiction, and demonstrated chronic non-compliance based on frequent use of acute inpatient hospitalization and/or avoidable emergency room visits. These Seniors are high consumers of healthcare resources and require daily, weekly to monthly contact from Care Managers to coordinate care for the multivariate medical conditions and issues contributing to non-compliance. It is anticipated that 10% of HCI-CCE's Senior enrollees require this level of care coordination.

Tier 2 (Supportive Standard Care Coordination) - will include Seniors with complex primary and/or secondary chronic conditions who may have bouts of medically instability but are relatively compliant and participatory in meeting care coordination goals. They require a moderate amount of coordinated, in-home health and community resources to avoid re-hospitalization or emergency room visits. Contact with a Case Managers will be monthly to quarterly. It is estimated that 15% of the HCI-CCE's Senior population will meet Tier 2 care coordination criteria.

Tier 3 (Service Coordination & Support) -will be Seniors with relatively stable primary and/or secondary conditions, mental illness or addiction that is in remission and who are

compliant with their care plans, but because their health status requires the need of some (3 or more) coordinated, community resources, they have a higher probability of medical regression. These Seniors will be monitored on a quarterly to semi-annual basis to ensure that their varied services continue to support their medical stability and compliance. Twenty-five percent of HCI-CCE's Seniors are anticipated to meet these criteria.

Tier 4 (Community Care Monitoring) – will be Seniors who have stable primary and/or secondary conditions, who are compliant and who may or may not have community care services (< 3 resources) but are not in need of any new coordinated, community services. Patient Navigators will contact these Seniors semi-annually to annually to ascertain whether their current services are meeting their needs. Regular contact will also maintain a relationship so that should a Senior's medical and/or support needs change, the Senior will contact HCI-CCE to assist with intervention at its most cost-effective provision. HCI-CCE expects approximately half of its Senior population will be in this tier.

Based on the tier level, changes in health status via direct notification or review of claims analysis data, or by Senior request, an inter-disciplinary team of a Senior's care and service providers will review and adjust the Senior's care plan to ensure it reflects the most successful approach to providing cost-effective, quality care to maintain and/or improve a Senior's health. Tier assignment will be a continually fluctuating process.

Seniors and their caregivers will be able to access their continuum of medical care and social services through a single telephone number which will be staffed on a 24/7 basis. The call center will be based in the south metro-Chicago area and predominantly staffed by representatives living in the proposed geographic area. The telephone number will be prominently displayed on the Senior's HCI-CCE identification card. Utilization of the phone number to access all medical and social services, as well as request patient education, will be reinforced during the initial assessment. Seniors will be encouraged to discuss care choices with a Care Manager or Patient Navigator prior to seeking medical care except in a medical emergency.

Meeting the Market Specific Needs

HCI-CCE recognizes that Seniors will have an option to choose whether or not to participate in care coordination, as well have options which care coordination model and entity they choose. To be successful in choice decisions as well as retention decisions, a CCE will not only need to incorporate standard customer service components, it will also need to incorporate the community in which the Senior lives.

To help bring focus back to community, the overall organization of the HCI-CCE’s care coordination will have Seniors divided into regions based on geography with a key collaborator hospital as an anchor. Having regional anchor hospitals as a key collaborator is crucial in maintaining access to care as well as being a centered point of transition to quality, responsive primary care physicians, medical homes or health homes in the community. Education and outreach geared toward the respective community’s culture will be facilitated by providing boundaries for outreach staff. This clustering of activities will not only provide structure for organization of the program, it will also support care coordination.

The following is the proposed regional organization:

<u>Anchor Hospital</u>	<u>Zip Codes</u>
University of Chicago Medicine	60615, 60653
Roseland Hospital	6019, 60620, 60627, 60628, 60643
St. Bernard Hospital	60621, 60636, 60637
South Shore Hospital	60617, 60633, 60649

HCI-CCE also understands that physicians, hospitals and other providers have choices in participating in care coordination and in which organizations they will participate. Quality care is assumed; cost factors will impact their choices. Fees will be direct billed to the State; however, on the provision of professional services, the reality is that time is money. This was contemplated in developing a model that streamlines communication. Providers and their staffs will be able to save time in determining where previous care may have been rendered as well as gathering necessary patient data from these multiple sources by utilizing the care plan. In addition, they will be able to maximize their efficiency in communicating with all providers through use of the care plan. Access will not be dependent upon operating business hours or physical location of records. Information can be accessed when needed, or convenient, for the provider 24/7 via the secure web portal.

Acknowledging that there will still be some time required to participate in care coordination, HCI-CCE has budgeted a portion of shared savings payments to be paid to providers who meet the established quality criteria. This reimbursement may be PMPM coordination fees and/or quarterly incentive payments. The parameters and form of these payments will be determined by the HCI-CCE Collaborator Council and approved by the HCI Board of Directors.

HCI External Relations staff will also regularly contact the providers to obtain assess their satisfaction with the care coordination process as well as to obtain feedback for improvements. High volume providers, as well as providers experiencing difficulties with the system, will have

face-to-face meetings to further facilitate the collaborative working relationships needed to provide care coordination.

The Care Plan

HCI-CCE will have a care plan (*Attachment K*) for each Senior as the documentation and communication repository for its care coordination program. It is the comprehensive, yet evolving, record of a Senior's care goals and outcomes. It includes strategies tailored to a Senior's specific needs and preferences to ensure that his/her goals are met. Care Managers and Patient Navigators will document in the care plan a Senior's care coordination goals, actions, responsible person and timeframes and progress/status in reaching the goal. In addition, specific attention will be given to record all medications prescribed for and taken by a Senior as the number of paid prescriptions may now be potentially limited. (Should there be an issue regarding prioritization in filling medication prescriptions, it will be brought to the attention of the Medical Director for appropriate handling.) Providers and Seniors alike will be afforded web-based access by which they may update their respective care plans, complete assessments and provide updates to assigned Care Managers and Patient Navigators via a secure, HIPAA-compliant web portal.

HCI-CCE will utilize Aetna's electronic care management system as the technological platform for its care coordination program. The system includes a Senior Profile (*Attachment J*) which details demographic data as well as the Senior's primary care and specialty physicians, behavioral health providers, risk assessment analysis and internal care coordination assignments. The care management system also stores and retrieves Seniors' clinical assessments, claims data, Care Plans and other care coordination documentation.

The final component of the care management system is Aetna's CareEngine® System. This will be utilized to increase Seniors' and providers' adherence to the care plan's clinical guidelines, improve the quality of healthcare for the Senior Enrollees and decrease medical costs. These goals are accomplished through: 1) using historic and current medical and pharmacy claims, and lab test results data to develop Senior-centered records, 2) comparing the Senior's data to existing clinical rules and algorithms, 3) identifying Senior-specific opportunities to optimize care and communicate evidence-based treatment recommendations to providers. By monitoring the objective data, HCI-CCE's Care Managers and Patient Navigators will be predict the likelihood of downward changes in health status and implement appropriate care strategies to mitigate any potential negative outcomes.

Monitoring Transitions through Care Coordination

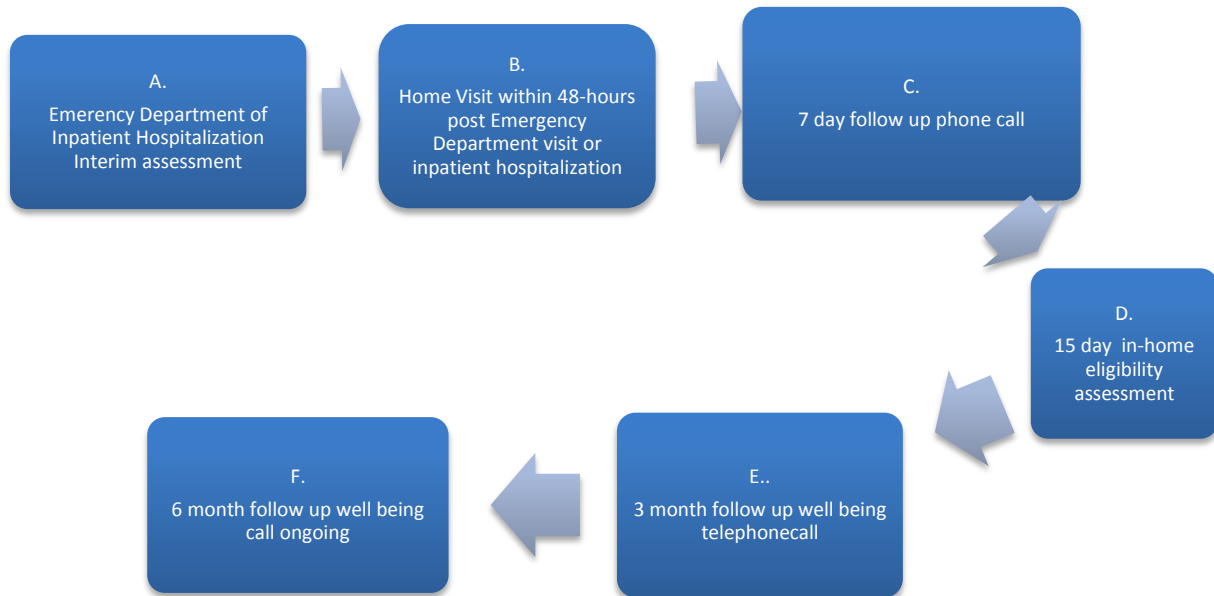
At regular intervals, an inter-disciplinary team of care and service providers will meet to review, modify and augment Care Plans (e.g., a "staffing"). Data reviewed during the staffing will

include the subjective information provided by the Senior and the Senior’s caregivers, the clinical information from the Senior’s providers, as well as the quantitative information from the predictive modeling tool that uses the State’s monthly claims data to predict the risk of healthcare utilization over the next 12 months. Intervals for Care Plan review will be based on the Senior’s Care Coordination tier:

Tier 1 (Intensive Care Coordination) -	Daily - Monthly
Tier 2 (Supportive Standard Care Coordination) -	Monthly - Every 3 months
Tier 3 (Service Coordination & Support) -	Every 3 - 6 months
Tier 4 (Community Health Monitoring) -	Every 6 months - Annually

In addition, any health status changes or unplanned utilization (e.g., emergency room visit, inpatient admission, etc.) during the interval will prompt an immediate Care Plan review. Should one of these events occur, the following process will be initiated:

Patient-Focused Transitional Care Flow Chart



Based on the outcome of the staffing, the Senior’s Care Coordination tier may be adjusted according to the changes in their risk status. Within the care management system, appropriate triggers will be set to notify all of a Senior’s known providers of the care rendered. As enrollment increases, it is the goal to have a Patient Navigator located within each of the collaborating hospitals (preferably in the Emergency Department) so that necessary data collection to assess the services required for discharge planning and care transition can begin immediately upon a Senior presenting for care.

Care Coordination Workforce

In addition to the administrative personnel delineated in the *Governance* section above, the Care Management staff is at the core of HCI-CCE’s personnel complement. Registered nurses (RN’s) will be Case Managers for Tier 1 Seniors. RN’s or Licensed clinical social workers (LCSW’s) will be Case Managers for Tier 2-4 Seniors. Patient Navigators will work with and report to the Senior’s assigned Case Manager.

To ensure that Seniors receive optimal monitoring and access to their Care Coordination Case Managers and Patient Navigators, the following staffing ratios will be maintained:

	<u>Case Manager</u>	<u>Patient Navigator</u>
Tier 1	1 to 50 Seniors	-
Tier 2	1 to 250 Seniors	-
Tier 3	1 to 1000 Seniors	1 to 250 Seniors
Tier 4	1 to 5000 Seniors	1 to 500 Seniors

(An organizational chart, key staff job descriptions and a staffing plan are in Attachment G with financial ramifications being delineated in the Three Budget in Attachment H).

Provider Network Development

As the Care Plan is a work in progress, so is Network Development. The guiding principle of HCI-CCE’s network development is to be a “network of networks”. The Director of External Affairs will facilitate reaching out to all providers on the Key Collaborator Hospital’s medical staffs to participate as a preferred provider in the HCI-CCE provider network. Specific coordinators will target reaching out to the Behavioral Health and Home Health/Non-Traditional providers to recruit additional providers beyond the key collaborators. Should it be determined that a provider of a Senior wishing to enroll in HCI-CCE is not a preferred provider, the appropriate Provider Network personnel will reach out to them for participation.

The network will also be enhanced by pursuing contracts with current Medicaid providers serving the HCI Senior Care population based on the outcome of the polling of current Senior Care Program clients. Lastly, the network will be enhanced by pursuing contracts with providers who are not in the presently a preferred provider, particularly those primary care providers, Medical Homes and medical, behavioral health and substance abuse specialists with experience in serving populations with chronic illnesses and complex physical and behavioral health care needs. HCI-CCE will map the network distribution based on the contracted participating preferred providers. In the event network gaps are identified, HCI-CCE will contact non-participating providers to determine potential interest in joining the network. Through this process, HCI-CCE will establish a base network that will be reviewed and refined on an ongoing basis. Efforts will focus on the continual development of network adequacy to best meet the special service needs of our Senior population.

Initial preferred provider requirements include:

- *Being a current Medicaid provider who meets credentialing criteria and accepts reimbursement at the established rates
- *Adhering to HCI-CCE's quality assurance initiatives and providing necessary medical, psychological and/or social information related to a Senior's care so it may be entered into the Care Plan
- *Following a Senior's care protocols and notifying HCI-CCE of a Senior's utilization of care without prior HCI-CCE notification
- *Abiding by other HCI-CCE provider policies and procedures as approved and implemented.

Only preferred providers will be eligible to participate in any HCI-CCE shared savings care coordination PMPM fees and/or quarterly incentive distributions if they meet the quality criteria.

HCI-CCE will provide initial and continuing education to its Preferred Provider network to guide them in timely, accurate, and HIPAA-compliant submission or release of Senior information to HCI-CCE and/or other appropriate entities. Preferred Providers will be educated through a Provider orientation, the Provider Manual, the Provider Portal to the Care Plan, and various targeted, periodic mailings. In addition, current information about disease management and prevention processes will be made available to the Preferred Providers.

All of these efforts are aimed at recruiting and retaining quality providers to ensure the following Provider to Enrollee ratios:

	<u>Target</u>	<u>Threshold</u>
Primary Care Providers	1 to 500	1 to 1,000
Specialists	1to 1,500	1 to 5000
Mental Health Providers	1 to 250	1 to 500
Substance Abuse Providers	1 to 250	1 to 500
Non-Traditional Providers (transportation, other community agencies)	*to be determined based on the provider	

Outreach

HCI is and has been an integral component of the proposed communities to be served. As an organization whose mission is to bring about change in healthcare through advocacy, awareness and action, outreach is a fundamental mechanism which allows HCI to achieve its goals. Outreach for HCI-CCE will be accomplished by utilizing and expanding upon HCI’s existing network of faith-based and other community-based organizations. Outreach efforts will be the responsibility of the External Affairs team.

Program-specific information on HCI-CCE will be provided on HCI’s existing business and patient education literature that it distributed at various town hall meetings and health fairs. HCI-CCE’s targeted outreach will include churches, beauty salons, food pantries, radio- and cable-based gospel shows, and senior walk clubs. In addition, the External Affairs team will reach out to the HCI-CCE collaborators and providers for Senior referrals who are not participating in any care coordination. The purpose of this outreach will be to assist a Senior in making informed care coordination choices that best suit their medical, psychological, and social needs.

To ensure that outreach materials can be easily understood by Seniors, their input on pieces will be sought during regularly scheduled community forums. All written materials will be available in English and other prevalent languages if more than 5% of the households speak a language other than English.

3.2.4 HEALTH INFORMATION TECHNOLOGY

Current Technology Capacity

Due to the diversity and breadth of HCI-CCE's collaborators and providers, a single Electronic Health Record will not be feasible during the initial term of the contract. In order to facilitate effective care coordination, HCI will work with Aetna Better Health to implement a broad spectrum of tools facilitating the exchange of health information with its collaborators and providers. A variety of HIT tools will be employed to support and enhance HCI-CCE's ability to coordinate care, monitor compliance, provide education and assess quality measures. This will include Aetna Better Health's electronic care management system, case management application, predictive modeling, and consolidated outreach and risk evaluation, Enrollee and provider web-based portal, and Active Health Care Engine and Care Considerations. These tools exist and are currently being used by Aetna and would be brought live at HCI-CCE prior to the program start date.

The electronic care management system stores and retrieves assessments, claims data, authorizations, Care Plans and Care Coordination documentation. HCI-CCE's Care Coordination teams will use the system to review Senior profiles and to facilitate coordination of physical health, behavioral health, home health and long-term care providers at multiple service locations, develop, share and review Care Plans, and monitor and track each Senior's appropriate use of services and health outcomes. The system also triggers alerts for HCI-CCE's Care Management team (e.g., service gap, medication issues) and other pre-defined reminders (e.g., reassessment needed, reminder call to schedule prevention screening). These alerts further assist the care management team in the effective management of each Senior's care.

Future HIT Capacity

HCI-CCE recognizes that technology is a rapidly changing field. Throughout the duration of the contract, new HIT resources that reach the market will be evaluated to determine if their adoption would be beneficial in further enhancing its operations. These will include telehealth and video-health monitoring. In addition, as the Illinois' Office of Health Information Technology works towards implementation of the Illinois Health Information Exchange (ILHIE) necessary to support HIE, HCI will continue to evaluate its HIT functionality.

Privacy and Confidentiality

HCI-CCE is dedicated to maintaining the privacy and security of protected health information of its Seniors. Safeguards will be in place to ensure that only authorized users have access to a Senior's protected health information. HCI-CCE will also employ appropriate technologies and

methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals. Not only will HCI-CCE have all appropriate administrative, physical and technological safeguards in place, but it will also require that its providers and business associates are HIPAA compliant prior to conducting business with HCI-CCE.

A 24-hour hotline will be maintained so that any issues related to privacy can be reported anonymously by anyone at any time. Should a breach, or the near occasion of a breach, be reported or suspected, an immediate assessment will be made. The goal of the assessment will be to identify any gaps in the safeguards and define necessary remediation strategies. Appropriate training for all involved will be a key component in not only remediating, but also preventing, any breaches of HIPAA rules and regulations.

In addition, as an ongoing part of its compliance program, HCI-CCE will assess its and its providers' and business associates' conformance with the safeguards on at least an annual basis. As compliance is a function of the legal department, any activities related to privacy and security matters can remain under the purview of attorney-client privilege to further ensure that all Senior's protected health information is subject to the additional layer of safekeeping. Lastly, HCI-CCE will work with providers and appropriate business associates to ensure that they qualify for and meet the requirements for meaningful use of electronic health records as defined in the HITECH Act – specifically the use of EHR to achieve significant improvements in care.

HIT Available Resources

Again, building off of its tenet of being a “network of networks”, HCI-CCE will make available to its collaborators/providers HCI's HIT resource network developed during its participation in the State's HIT Exchange. This includes, but is not limited to, electronic health record vendors, network vendors, and IT infrastructure vendors. Utilization of these resources will be independent of HCI-CCE and at the discretion of the collaborator/providers.

3.3 FINANCIAL MODEL

CCE Reimbursement

HCI-CCE is proposing a Care Coordination Fee with Pay for Performance incentives as its reimbursement option. Providers (medical, ancillary, and non-traditional) will continue to bill for services directly to the State or CMS under their existing Fee-for-Service arrangements.

The proposed PMPM Fees are:

Tier 1 (Intensive Care Coordination) -	\$609.75 PMPM
Tier 2 (Supportive Standard Care Coordination) -	\$308.05 PMPM
Tier 3 (Service Coordination & Support) -	\$139.35 PMPM
Tier 4 (Community Health Monitoring) -	\$ 28.75 PMPM

The proposed PMPM Fee structure is stratified according to tiers reflective of the level of care coordination required. The base rate was predicated on current IDoA care coordination fees; higher tier rates were extrapolated based on the increasing time and expertise of personnel required to facilitate effective care coordination.

A Senior's initial assessment and ongoing care plan review will dictate which tier a Senior is assigned. However, a Senior's health status may fluctuate; therefore, the care coordination tier may vary. A pro forma allocation of Seniors within the tiers was provided by Aetna Better Health and anecdotally validated by HCI's IDoA Senior Care experience and utilized for both budgetary and cost savings projections. It is estimated that the average monthly distribution of Seniors will approximate:

Tier 1 (Intensive Care Coordination) -	10%
Tier 2 (Supportive Standard Care Coordination) -	15%
Tier 3 (Service Coordination & Support) -	25%
Tier 4 (Community Health Monitoring) -	50%

Combining the proposed PMPM Fee Structure with the estimated Senior Tier Distribution and enrollment projections, the following blended PMPM is calculated:

\$156.50 PMPM.

It is HCI-CCE's intent that the State only be charged for the level of care coordination actually provided to a Senior during the month; however, this increased administrative cost associated with monthly billing is contradictory to the intent of the Solicitation. Therefore, HCI-CCE proposes that it be paid the blended PMPM for each enrolled Senior with an annual reconciliation of fees paid to care coordination provided.

In addition to the CCE Incentive Payments delineated in Attachment B-1, HCI-CCE is proposing the additional quality measure #1, Behavioral Health Risk Assessment and Follow-up. As this is an integral part of its care coordination program, it is appropriate that it be utilized as a quality measure. As the budget was prepared conservatively, only 50% of the eligible pay-for-performance incentive payments are projected to be attained; the goal is to receive 100% of the payments.

HCI-CCE is also proposing participating in shared savings. HCI-CCE's target population includes dual-eligible and non-dual-eligible Seniors. Per subsequent notification from the State, a CCE who serves dual eligibles will not have Medicare savings available for sharing, only Medicaid savings they can generate. In reviewing the data provided by the State, the single largest area for cost savings is nursing facility utilization. HCI-CCE proposes this as a new shared savings quality measure. Again, as the budget was prepared conservatively, only this shared savings measure is included. The goal is to meet all of the cost savings quality measures and receive full cost savings (but no more than total costs generated less program costs).

At this time, HCI-CCE is not contemplating advancing to become a risk-assuming MCCN. HCI-CCE believes it is necessary to maintain a care coordination program to serve the Seniors who wish to voluntarily enroll in a CCE with fee-for-service arrangements.

Cost Neutrality

Through HCI-CCE's care coordination, it is anticipated that the State will not only experience cost neutrality, it will have the benefit of cost savings.

HCI-CCE's proforma revenue is projected to be \$11.7M over the three year contract period. The three year budget in *Attachment I* provides a detailed description of annual revenue and expenses (including personnel, operations, health information technology and other costs). Approximately, \$1.1M of this represents care coordination fees that HCI currently receives from the Illinois Department of Aging; these fees would no longer be billed to IDoA. Approximately \$10.6 would be new costs incurred by the State.

Projected cost savings from care coordination are ~\$11.9M over the three year contract period. HCI-CCE's cost containment efforts would focus on reductions in admission and lengths of stays in acute care hospitals, psychiatric hospitals and nursing facilities. Emergency Room utilization

would also be proactively supervised. Due to the reduction in inpatient activity, physician costs would decrease. Any increases in in outpatient physician costs due to the transition from outpatient to inpatient settings would be offset by volume reduction due to deletion of duplicitous visits, as well as an overall fee reduction due to outpatient reimbursement being less than inpatient reimbursement. Non-ER transport services would be dramatically reduced due to coordination of multiple testing and physician visits on the same trip. Prescription drug costs could further be reduced by managing in the number of prescriptions for Seniors who have less than new State threshold of four per Senior. The chart below delineates the estimated savings achieved through HCI-CCE's care coordination.

2010 ACTUAL	Dual	Non-Dual	TOTAL
# of Enrollees	15,947	1,434	17,381
Total Expenditures	\$125,628,647	\$18,811,149	\$144,439,796
Per Enrollee Cost	\$ 7,878	\$ 13,118	

PRORATED FOR ENROLLMENT	Year 1		Year 2		Year 3		TOTAL	
	Dual	Non-Dual	Dual	Non-Dual	Dual	Non-Dual	Dual	Non-Dual
# of Enrollees	600	400	2,000	500	4,000	1,000		
Total Expenditures	\$4,726,732	\$5,247,182	\$15,821,251	\$6,558,978	\$31,511,544	\$13,177,956	\$52,059,527	\$24,984,116
Per Enrollee Cost	\$7,877.89	\$13,117.96	\$7,910.63	\$13,117.96	\$7,877.89	\$13,177.96		
PROJECTED COST SAVINGS								
Emergency Room	(\$405)	(\$11,597)	(\$1,351)	(\$14,497)	(\$2,703)	(\$28,995)	(\$4,459)	(\$55,089)
Inpatient-Other	(\$95,733)	(\$351,691)	(\$319,118)	(\$439,613)	(\$639,445)	(\$879,226)	(\$1,054,296)	(\$1,670,530)
Inpatient - Psych	(\$3,396)	(\$21,981)	(\$11,321)	(\$24,476)	(\$22,641)	(\$54,951)	(\$37,358)	(\$101,408)
Non-ER Transport	(\$43,375)	(\$19,097)	(\$144,584)	(\$23,871)	(\$289,168)	(\$47,742)	(\$477,127)	(\$90,710)
Nursing Facility	(\$450,785)	(\$251,841)	(\$1,502,616)	(\$314,801)	(\$2,991,942)	(\$629,602)	(\$4,945,343)	(\$1,196,244)
Other Practitioners	(\$51,897)	(\$68,692)	(\$172,989)	(\$85,865)	(\$345,979)	(\$171,730)	(\$570,865)	(\$326,287)
Outpt/Clinic/Lab	(\$20,232)	(\$78,213)	(\$67,443)	(\$97,767)	(\$134,885)	(\$195,533)	(\$222,560)	(\$371,513)
Physician Services	(\$10,855)	(\$40,534)	(\$36,183)	(\$50,667)	(\$72,366)	(\$101,335)	(\$119,404)	(\$192,536)
Prescription Drug	(\$8,597)	(\$71,451)	(\$28,648)	(\$89,314)	(\$57,295)	(\$178,628)	(\$94,540)	(\$339,393)
TOTAL SAVINGS	(\$685,275)	(\$915,097)	(\$2,284,253)	(\$1,140,871)	(\$4,556,424)	(\$2,287,742)	(\$7,525,952)	(\$4,343,710)
Projected Enrollee Cost w Savings	\$ 6,736	\$ 10,830	\$ 6,768	\$ 10,836	\$ 6,739	\$ 10,890		

Data used to calculate the savings projections came from information contained in Dataset I.

Utilization of Profits

As a not-for-profit, HCI must re-invest net profits from this program in the community it serves. Net Profits will be defined as Revenues less expenses and reserve requirements as calculated on a cumulative basis (i.e., any net operating deficits must be covered prior to profit re-investment or shared savings payments). Once operating on a continued profitable basis, a portion of the net profits will be put in reserve to avoid disruptions in service due to variable business conditions. An adequate reserve will be set aside prior to re-investing profits in the community or distributing incentive payments.

It is anticipated that the community re-investment portion of net profits will be used to assist Seniors in obtaining non-covered services or curtailed services per recent budget actions (e.g. required prescription assistance beyond four prescriptions, dental procedures to prevent exacerbations of medical conditions, etc.) to maintain a Senior's care coordination at a lower Tier level. In addition, a portion of the shared savings reimbursement may be considered for provider quality performance incentive payments.

The HCI-CCE Collaboration Council will be tasked in making recommendations for protocols and parameters for reserve allocations, community re-investment, and provider quality performance incentive payments. For budgetary purposes, twenty five percent of profits are placed in reserve; twenty five percent of shared savings are proposed for provide quality performance incentive payments. Any recommendations must be approved by the HCI Board of Directors prior to implementation.

HCI-CCE will not be requesting an advance on the care coordination fee to assist in the development of the CCE infrastructure prior to implementation.

CONCLUSION:

HCI-CCE's care coordination program is submitted in response to the *State of Illinois Solicitation for Care Coordination Entities and Managed Care Community Networks for Seniors and Adults with Disabilities – Innovations Project/2013-24-002*. Its details are specific in meeting the requirements of the solicitation with respect to its proposed population; however, the care coordination model itself was developed taking into account the observed needs of all receiving healthcare services, regardless of payer, age or geographic area. The model is geared to provide seamless transitions for people as their healthcare needs evolve – not only between phases of care (inpatient vs. outpatient vs. long term care) but also between payers (Medicare vs. Medicaid vs. commercial products) and therefore can be replicated and expanded as needed. Because of its specificity in meeting the solicitation requirements while having versatility to be used for myriad populations in varied geographic locations, HCI-CCE is deserving of award of a CCE contract.