ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

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CARE COORDINATION PLAN AND TIMELINE
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Current Status:

The Department of Healthcare and Family Services (HFS) currently manages 4 programs of capitated managed care for the Medicaid population: Three of these programs are voluntary for clients who are children and their parents; about 200,000 have enrolled.

The remaining program is mandatory for about 40,000 clients who are Seniors and Persons with Disabilities ("SPD", formerly "AABD"), who are in the process of being enrolled in the new Integrated Care Program in the suburbs and collar counties. As of July 12, there have been 17,169 enrollments into the Integrated Care Program, with 8,851 members (52%) joining Aetna Better Health and 8,318 (48%) joining IlliniCare Health Plan.

Illinois Law:

The new Medicaid reform law states that Illinois must enroll 50% of the Medicaid population in "care coordination" by January 1, 2015. This means at least 1.5 million of our Medicaid clients – children, parents, seniors and disabled persons – will be assigned to an integrated healthcare delivery system replacing the current fee-for-service fragmented system. Under the Affordable Care Act, as of January 1, 2014, about 700,000 Illinoisans currently without health insurance will be eligible for Medicaid for the first time; it is expected that all of these new applicants will be enrolled with care coordination entities.

Care coordination is defined broadly to include both traditional managed care companies as well as new alternative models of care organized and managed by hospitals, physician groups, Federally Qualified Health Centers (FQHC) or social service organizations. Care coordination entities must provide or arrange for a majority of care around the patient's needs, including a medical home with a primary care physician, referrals to specialists, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, and when appropriate, 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.

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Phase I FY2012 Plan:

In May, HFS issued a white paper on Policy Issues in Care Coordination, listing a set of complex policy issues that must be resolved in order to develop and implement care coordination in Illinois. To date, we have received about 75 responses, indicating tremendous community interest in testing new coordinated service delivery systems. We will hold public hearings or "conversations" to focus on areas of complexity or on issues where there is no consensus.

HFS will develop the Innovations Project as Phase I in order to test community interest and capacity to provide alternative models of delivering care (i.e. not through traditional HMOs) -- serving children/families, special populations, and seniors/persons with disabilities. HFS and partnering state agencies will develop the process of soliciting proposals from a wide range of community providers.

The Innovations Project solicitation process is expected to be announced by the end of year, 2011, with a timeline that gives 4-5 months to potential care coordination entities to submit proposals. During this period, they will likely need to analyze Medicaid data for the population to be served, to organize networks and partners, and to fully develop their systems of care. The state will also need time for required federal approvals of possible new waivers and state plan amendments. Awards should be announced by the summer of 2012.

Concurrent with the development of the Innovations Project, HFS will seek to reform the hospital rate reimbursement system. There are numerous deficiencies in the current rate system; this fact is widely acknowledged by the hospital community as well. However, the most significant problem for the state with the current hospital reimbursement system is that claims-based payments, those tied directly to services, account for just 58% of all payments to hospitals. Static, lump sum, supplemental payments, unrelated to current utilization, comprise 42% of hospital reimbursements. This makes the current system incompatible with the law requiring 50% of clients to be enrolled in care coordination. The collaborative effort between the state and the hospital community to reform the rate structure, currently underway, will achieve a smoother transition to the 50% goal and create the foundation for value-based reimbursement based on quality care.

Phase II FY2013 Plan:

Phase II is envisioned to increase care coordination on a much larger scale. At this time, the degree of community provider response to the Innovations Project is unknown, as is the percentage of Medicaid clients that will be served in alternative models of care. Phase II will add to the population served in care coordination, and likely will include traditional managed care companies as well as other models of care. A solicitation process for Phase II services will begin in summer, 2012. However, prior to implementing large-scale risk and/or managed care/care coordination, it is essential that hospital rate reform be accomplished through legislation.

For more information, please contact Theresa Eagleson, Medical Programs Administrator, 217-782-2570.