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Pat Quinn, Governor
Julie Hamos, Director

E-news

October 2012



Illinois Department of Healthcare and Family Services

Greetings from HFS Director Julie Hamos

Welcome to another periodic edition of HFS E-news to keep you updated on program changes. To register for future editions, please visit [HFS E-news Online Registration](#) or [download for others](#) who might be interested by visiting:

<http://www2.illinois.gov/hfs/PublicInvolvement/enews/Pages/default.aspx>

If you are a Medicaid client, this newsletter is not the official notification of any changes that may impact you, and you do not have to respond in any way. This is general information for the public.

Thank you,

Julie Hamos

Care Coordination Update

HFS is pleased to announce that we have made initial awards to six entities for the Innovations Project. They were selected based on their demonstrated ability to offer a holistic approach to delivering coordinated care for special populations, including seniors and adults with disabilities. HFS has told the other 14 provider organizations, not selected in the first round that we would like to work with them to explore possible enhancements to their project proposals. The state expects to select additional participants in the next year.

As a reminder, the Innovations Project includes provider-organized networks of care that will include, at a minimum, coordination of primary care, hospital services and behavioral healthcare. The initial awards are anticipated to extend for a three-year term, with possible extensions based on specific quality and savings measurements assessed, under each model, during the initial term. Each entity will serve 500-1,000 Medicaid clients in the first year, as they establish and test their care coordination models, before expanding in the following years. Care coordination fees will be paid based on performance, but the plan must be at least cost neutral over three years, through reduced use of emergency rooms, reduced hospital admissions and readmissions, follow-up care and other strategies.

HFS will collect detailed data from each model and the data will be used to measure, and assess, the performance of the various models of care coordination.

These are the six entities selected -- four in the Chicagoland area, and two in downstate Illinois:

Care Coordination Entities (CCEs):

Be Well Partners in Health – As a CCE, the proposed care coordination model will be led by MADO Management LP, Bethany Homes and Methodist Hospital, Norwegian American Hospital and Neumann Family Services. It includes a network of collaborators, within the community, that are Primary Care Physicians, Mental Health Providers, Substance Abuse Providers, and others. The focus of this model is on improving health outcomes for adults with severe mental illness and chronic health conditions, including substance abuse, on the North Side of Chicago. This Innovations Project will test a care coordination model organized by a nursing facility group, with its unique insight into long-term services, and an additional focus on care coordination services within long-term care settings.

Healthcare Consortium of Illinois – As a CCE, the proposed care coordination model will be led by the Healthcare Consortium of Illinois, a community-based, non-profit organization, and includes a network of collaborators within the community that are Primary Care Physicians, Behavioral Health Service Providers, Hospitals and others. The focus of the Consortium’s care coordination model is a Comprehensive Care Plan, which is managed and monitored by an evidence-based process for seniors and their eligible family members, in 13 Zip codes on the South Side of Chicago. This Innovations Project will test a model organized by a community-based organization that promotes the concept of “networks within networks,” with its base of hospitals, physicians and social service organizations.

Macon County Care Coordination – As a CCE, the proposed care coordination model will be led by the Macon County Mental Health Board, with a network of collaborators that includes a Federally Qualified Health Center for primary care, Hospitals, Behavioral Health Service Providers, a Health Department and others. The focus of the collaborations care coordination model is to promote coordination and communication of social support, and medical services across different organizations and providers for adults with serious mental illness, seniors with chronic illness, including dual eligibles, and children and family members of adult enrollees in Macon County. This downstate Innovations Project, organized by a county-based mental health organization, will be used to demonstrate the effectiveness of care coordination led by mental health providers.

Precedence Care Coordination – As a CCE, the proposed care coordination model will be led by Precedence CCE, which represents a newly established collaboration of providers and community organizations including hospitals, substance abuse entities, clinics and three established community mental health centers. The CCE is proposing to serve adults with disabilities, including adults with serious mental illness and/or substance abuse disorders across a nine-county region in Northwest and Central Illinois. The regions include Whiteside, Lee, Rock Island, Bureau, Henry, Mercer, Stark, Marshall, Putnam and LaSalle counties, and combine both rural and urban demographics. The Innovations Project tests a model organized through a major hospital system, featuring integration of primary and behavioral care with community health agencies through health home hubs.

Together4Health – As a CCE, the proposed care coordination model will be led by Heartland Health Organization, Inc., and includes 37 collaborators: hospitals, primary care providers at Federally Qualified Health Centers, pharmacy, behavioral health providers, social services and housing providers. The collaborators care coordination model is based on the health home setting, and will be an integrated, holistic approach that promotes physical, mental and social well-being, while improving access to care, for adults and seniors with disabilities, including those with serious mental illness and people who are dually eligible, in Cook County. This Innovations Project brings a unique focus on serving hard to reach populations,

including the homeless, with a care model that is attuned to housing and other social determinants of health.

Managed Care Community Network (MCCN):

Community Care Alliance of Illinois – As a MCCN, the proposed care coordination model will be led by Community Care Alliance of Illinois, a wholly-owned subsidiary of Family Health Network, and includes over 40 hospitals and 6,000 practitioners. This MCCN’s care coordination model proposes to serve seniors and persons with disabilities, including those with severe mental illness and intellectual/developmental disabilities in Anchor Medical homes that address six domains of care: medical, psychological, functional, environmental, social support and financial. The MCCN is proposing to serve eligible individuals in Cook and surrounding counties. This Innovations Project is unique in that it borrows from a successful model pioneered by Dr. Robert Master, CEO of the Community Care Alliance in Boston, who serves on the MCCN’s National Advisory Board. It is the only full-risk proposal submitted to the Department.

Please feel free to ask questions or share comments by e-mailing the [HFS Webmaster](mailto:hfs.webmaster@illinois.gov):
hfs.webmaster@illinois.gov