Illinois Medicaid Managed Care Provider Perspectives  
Presented at HFMA Spring Symposium  
April 11, 2016  
Robert Currie, President  
Community Care Alliance of Illinois

Learning Objectives

- Understand the evolution from Fee-for-Service (FFS) to Alternative Payment Models in Illinois Medicaid Managed Care
- Overview of the past and current Illinois Medicaid managed care programs
- How Participating Plans leverage incentives
- Understand the components and goals of APM rate setting
- The role of Care Coordination in alternative payment methodologies
- The role of Quality in alternative payout methodologies

What Prompted the Serious Re-examination of FFS Payment Model In Illinois?

- Increasing health care costs as a percentage of budget
- Offer new funding incentives and flexibility
- Promote risk-based funding arrangements
- Align Medicaid payments to initiatives that improve care for enrollees
- Success seen in other states

Chronology of Managed Care Programs In Illinois

- 1976 - Voluntary Managed Care (VMC)
- 1994 - Proposed mandatory program
- 2006 – Illinois Health Connect (IHC)
- 2011 – Integrated Care Program (ICP)
- 2013 – MMAI, ACE and CCE
- 2016 - MLTSS
Early Participating Plans
• Roosevelt Health Plan (became Chicago HMO)
• Michael Reese Health Plan (Staff model)
• Compass (Hospital sponsored)
• Humana
• Unity HMO
• Amerigroup
• Harmony
• Family Health Network

The Long and Winding Road of Illinois Medicaid Managed Care Organization Participation
• 1976 – 1 MCO
• 1995 - 18 MCOs
• 2009 - 3 MCOs
• 2011 - 5 MCOs
• 2015 - 13 MCOs, 9 ACEs, 6 CCEs
• 2016 – 10 MCOs, 0 ACEs, 1 CCE

What is the future growth for Illinois Medicaid Managed Care?
• In 2011, 195,000 in Medicaid managed care
• In 2016, 2 million insured Medicaid recipients in managed care
• In 2017, projected 2.1 million enrollees
• Managed Care penetration of 65%
Typical Alternative Payment Models

- PMPM Payments and Medicaid FFS
- Medical Homes
- Medicaid Health Homes
- Episodic or Bundled Payments
- Accountable Care Organizations
- Dual-Eligible Integration Models

Alternative Payment Model Rate Setting

- Rates are set through an administrative process
- Milliman conducts the actuarial analysis
- Age, gender, geographic and utilization factors
- Managed care savings
- Global capitation

ICP REGION 6 - CHICAGO METRO

What changes in the physician role are inherent in a managed care environment?

- Increased attention to overall costs and the coordination of services among all providers
- A proactive role in managing the patient's care by other providers
- Overseeing care in a continuum of sites — home, acute care hospital, long-term care facility
- Quality metrics
Flow of ICP Premium-2014

Risk Adjustment

Cook County Access Fee ($10.00 PMPM)

Hospital Services Fund (33.6%) $xxx

Medical Services Fund (36.3%) $xxx

Net Premium Remaining $xxx

Risk Reserve (20.9%) $xxx

Incentives Paid to Providers $xxx

Paid RX Claims 13

Transforming Care Coordination

- Collaboration between MCOs, ACEs and CCEs is leading to powerful alignments that mean improved coordination and quality
- Combining best of both worlds:
  - Managed Care Organizations offer superior risk and quality management, analytics and contracting expertise
  - ACEs/CCEs offer vital clinical, community and frontline experience
- Transforming approach from paying for volume to paying for value and outcomes

Quality Performance Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Care</td>
<td>• Comprehensive Diabetes Care</td>
</tr>
<tr>
<td></td>
<td>• Statin Therapy for Patients With Diabetes</td>
</tr>
<tr>
<td>Medication Management</td>
<td>• Annual Monitoring for Patients on Persistent Medication</td>
</tr>
<tr>
<td></td>
<td>• Medication Management for People With Asthma</td>
</tr>
<tr>
<td></td>
<td>• Use of High-Risk Medications in the Elderly</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>• Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
</tr>
<tr>
<td></td>
<td>• Follow-Up After Hospitalization for Mental Illness</td>
</tr>
</tbody>
</table>

Quality and P4P Measures
Integrated Care Program – Care Coordination Fee

- Care Coordination Fee PMPM ranges from $4 to $18
- Physical Accessibility (Per ADA federal guidelines)
- handicapped parking
- access from outside (curb, ramp, lift)
- wheelchair access
- wide corridors
- wide doorways
- waiting-room space
- accessible front desk
- wheelchair scale
- wheelchair bathrooms
- adjustable height tables
- patient lift
- Communication: ASL, Bilingual
- Encounter Data Compliant

Integrated Care Program - Medical Home Fee

- Patient Centered Medical Home by a recognized accrediting body
- Recognized as an Anchor Health Home by Plan
- Systems Capability
- Membership Threshold
- Model of Care Training

Integrated Care Program - Health Risk Assessment Fee

- HRA Risk Tier Component
- HRA Tier Amount (PMPM)
- No HRA-$0
- T3 – Low $2
- T2-Moderate $4
- T1 – High $7

What’s Ahead

- HFS complete final ACE and MCO transition
- HFS adds new populations
  – MLTSS
  – DCFS Population
- Together HFS and MCOs move from Medicaid migration to Medicaid Transformation