HFMA Lone Star

Building a Statewide Clinically Integrated Delivery System

January 28, 2016
Agenda

I. Setting the Stage
II. IPH Formation
III. IPH Current State
IV. Lessons Learned
Today’s Objectives

The purpose of today’s presentation is to:

- Discuss the dynamic environment for Medicaid managed care in Illinois.
- Discuss the innovative, statewide approach to developing a clinically integrated delivery system known as the Illinois Partnership for Health (IPH).
- Review the key components of the model (clinical, financial, information technology [IT], network, and governance).
- Discuss the operational challenges in a changing environment.
- Share lessons learned and best practices.
I. Setting the Stage
Impetus for Change

Our healthcare system is on a trajectory of insolvency. Healthcare organizations will have to collaborate to succeed in value-based delivery models, working together to develop best practices and standardized care delivery, which will result in improved patient care and costs.

- Uncontrollable, increasing healthcare costs
- Inadequate quality
- Insufficient access to care and information
- Inconsistency and inefficiency in care delivery
- Increase in chronic conditions such as obesity, diabetes, heart failure, and hypertension
- Aging population
- Workforce shortages (physicians and other)
- Payor contracting shifting from volume to value
Furthermore, the nation is looking to healthcare organizations to innovate and improve care delivery through better coordination and more efficient use of resources, while simultaneously reducing costs.

This movement to value-based care entails a shift from the previously fragmented and inefficient healthcare system to a focus on the patient’s total healthcare picture across the full continuum of care.
I. Setting the Stage
Chicago Medicaid Reform Law

Responding to various pressures and market forces, a plan was developed to move the Illinois Medicaid program from a fundamentally fee-for-service (FFS) system to one that promotes value and health outcomes.

» The Illinois Medicaid Reform Legislation (enacted in January 2011) required the state to enroll 50% of Medicaid individuals in “care coordination entities” by January 1, 2015.

» The 50% requirement to be accomplished through enrollment in managed care organizations (MCOs) and other types of care coordination entities (CCEs), such as an accountable care entity (ACE) established by the state.

» The ACE program is modeled after the federal government’s CMS ACO initiative.

» An ACE is required to be an integrated delivery system with the capacity to securely pass clinical information across its provider network; the ability to aggregate/analyze data to coordinate care; and a model of care and a financial management structure that promote provider accountability, quality improvement, and enhanced health outcomes.

Like other successful ACO efforts, this ACE program is designed to provide better health and better care options for Medicaid recipients—while reducing costs for that care.
At the end of 2013, 3.1 million individuals were enrolled in Illinois Medicaid. This is up approximately 400,000 enrollees since Medicaid expansion through the ACA legislation. Approximately 70% of this enrollment in 2013 was in some managed care entity, such as an ACE.

**ACE Program**

» **Definition** — An ACE is an organization composed of and governed by its participating providers. It is accountable for the quality, cost, care, and overall outcomes of its enrollees through an integrated delivery system.

» **Population** — The ACE serves the Family Health Plan population and Affordable Care Act (ACA) adults who are eligible for Medicaid.

» **Solicitation** — HFS issued a solicitation in September 2013 for organizations to become an ACE.

   ‒ The solicitation outlined over 65 requirements within five categories: organization/governance, network, care model, IT, and financial model.

» **ACE Contract** — HFS awarded the IPH an ACE contract in February 2014.

» **Enrollment** — ACE enrollment began in mid-July 2014 and was phased in.

» **Future State** — During the first 18 months of operation, the IPH received per member per month (PMPM) CM fees and shared savings. Thereafter, the IPH transitioned to an MCO, accepting full risk for the total cost of care associated with its ACE patient population.
II. IPH Formation
Founder Organizations

Nine health systems, their employed and affiliated providers, and an experienced payor joined together in a collaborative effort to form the IPH, also known as the “Super ACE” of Illinois.

The network of the original nine Founder organizations represented:

» 64 of the 102 counties of Illinois.
» The capacity to serve 126,000 enrollees.
» More than 8,000 individual providers.
» 63 inpatient acute care facilities.
II. IPH Formation
Care Delivery Model

The IPH developed a care model that fosters sharing best practices to ensure improved care delivery and health outcomes over time.

Hybrid Approach
The IPH care model allows for some regional variation on executing care model components but develops a central framework with consistent core competencies and measures across the IPH.

» **Patient- and Family-Centered** — Built on the NCQA patient-centered medical home (PCMH) model, ensures a consistent framework that is focused on patients and their families

» **Comprehensive, Coordinated Care Delivery** — Focuses on coordination across the entire continuum of care: PCPs, specialists, hospitals, behavioral health, social support services, and other facilities

» **Independence and Collaboration** — Allows for the ability to maintain independence while collaborating and coordinating to enhance and improve healthcare for the Medicaid patient population

» **Shared Best Practices** — Leverages best practices and evidence-based medicine among innovative, forward-thinking organizations that are already recognizing improvements in care, quality, and costs

» **Standardization and Consistency** — Standardizes clinical protocols and customizes work flow changes, decision support tools, and reporting to manage the Medicaid population across the IPH

» **Continuous Improvement** — Utilizes continuous improvement techniques and tools to ensure the highest performance in an evolving care delivery system as patient needs change

» **Implementable Solutions** — Leverages thoughtful and realistic solutions through a phased-in approach, allowing incremental change management in an evolving, fast-paced environment
## II. IPH Formation

### Care Delivery Model (continued)

The central elements of the IPH care model are shared across all Founder organizations, with some variation for how these elements are implemented at each local organization.

<table>
<thead>
<tr>
<th>Standardized Policies</th>
<th>Risk-Based Intervention</th>
<th>Care Teams</th>
<th>Disease Management</th>
<th>Quality Measurement</th>
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<td>Each organization agrees to adopt mutually developed policies for care coordination and delivery.</td>
<td>IPH stratifies patients into high, medium, and low risk categories to assign care team members and determine interventions needed and the timing of interventions.</td>
<td>Multidisciplinary care teams are assigned based on risk level to address the specific needs of patients, including clinical, social services, behavioral health, and other needs managed through the PCMH model.</td>
<td>IPH leverages disease management guidelines across Founder organizations for most chronic conditions and other services, such as dental, pharmacy, LTC, and reproductive health.</td>
<td>The ACE program requires the reporting of 28 different quality measures; many are HEDIS measures, others are state measures, and a few are NCQA measures.</td>
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The ACE program focuses on enhancing data exchange across Illinois health information exchanges (HIEs) and other tools to support the care model. The IPH has a long-term vision of greater sophistication through a centralized PHM platform.

» Electronic health record (EHR) use is required at specific percentages by provider type and specialty.

» EHRs are used for decision support and to implement standardized disease management protocols.

» Providers are required to participate in HIEs at specific percentages by provider type and specialty, but multiple nonintegrated HIEs are being used.

» Specific transaction types are required at certain transitions of care.

» The ACE program requires that specific quality measurements be reported.

» Additional financial and clinical measurements were identified to monitor program effectiveness.

» Functionality was developed to stratify patients, identify clinical risks, and support outreach to patients.
II. IPH Formation

Provider Network

The ACE program required the maintenance of network adequacy and demonstrated capacity to serve the enrollee population.

Initial Network and Contracting Strategy

» The initial network included all employed and closely affiliated providers of Founder organizations.
  › The IPH developed contracts for community providers to participate in the IPH for those provider groups that closed major network gaps in each market.
  › Participation criteria were built into the contract to account for care model standards and IT use.
  › Each organization executed contracts in its region on behalf the IPH.

» HFS evaluated network adequacy for PCPs, specialists, and facilities using the 30-60-90 rule.

Phase 2 Network Development Strategy

» Over the first 18 months of the program, the IPH set out to execute new contracts with the targeted network. These contracts would represent terms negotiated between providers and the IPH as a payor.

» Certain specialty groups in particular markets had to be considered strategically because of low Medicaid reimbursement rates.
II. IPH Formation

Financial Model

The IPH developed a comprehensive financial model to ensure its sustainability, inclusive of all Founders.

» **Contract Term and Type** — The contract with HFS had an initial 18-month term, with the intent to evolve the contract toward a shared-risk arrangement by Month 19.

» **Provider Payments** — During Months 1 through 18, providers would continue to submit claims and receive standard FFS payments directly from the state at 100% of then-current Medicaid. After Month 19, all claims submissions would be made to the IPH, and payments made directly from the IPH.

» **PMPM CM Payments** — ACEs were paid a CM fee of $20 PMPM for ACA adults and $9 PMPM for all other enrollees from HFS to pay for infrastructure costs associated with CM. A portion of the fee was retained by the IPH to cover operating costs and establish reserves for meeting the program requirements for becoming an MCO and the remainder was distributed to the Founders.

» **Shared Savings** — PCPs (and other affiliated providers) were eligible to receive shared savings distributions if savings are achieved and pay-for-performance (P4P) standards are met for PCP attributed members based on the quality measures required for the program.
II. IPH Formation
Funds Flow and Payment Methodology

Initially, the IPH did not assume full financial risk and did not manage claims.

HFS → IPH

PMPM CM (Portion to HAMP and Founders + Shared Savings [15% to ACE])

- Blessing Health System
- Cadence Health
- Decatur Memorial Hospital
- KishHealth System
- Memorial Health System
- OSF Healthcare
- Riverside HealthCare
- Rockford Health System
- The Carle Foundation

Shared Savings (Up to 85% to Provider Network)

- Hospital: Paid FFS + Shared Savings 50%
- PCP: Paid FFS + PMPM CM + Shared Savings 50%
- OB/GYN: Paid FFS + Performance Bonus
- Specialist: Paid FFS
- Behavioral Health: Paid FFS
After 6 months, there was a change in leadership at the Illinois governor’s office and HFS announced several adjustments to the ACE program.

Changes Announced

» Funding for care coordination PMPM fees had run out and would no longer be paid.

» ACEs were asked to accelerate their progression toward an MCO model from an 18- to a 6-month timeline.

Challenges

ACEs were challenged to meet this request for several reasons:

» Infrastructure to support a full-risk model had not been fully developed.

» The experience with the new PHM-focused care model was more limited than what the Founders had anticipated.

» The timeline for acquiring an insurance license was not feasible.

» The number of contract changes and requirements was not realistic.

» Monthly enrollment was an upward of 20,000 members per month, which was not manageable with all of the changes.

Pursuing the original strategy at an accelerated timeline was not feasible, so the IPH looked at alternative solutions.
III. IPH Current State

Legislative Changes (continued)

In order to maintain its membership, the IPH needed a health plan partner with an insurance license and authority to offer products in the same service area as IPH.

IPH Response to Changes

» IPH considered various partnerships and potentially becoming its own insurance product, but that wasn’t feasible given the new timeline and contract requirements.
» Health Alliance Medical Plans (HAMP) was contracted to provide delegated services to the IPH and was licensed as an MCO in Illinois.
» The IPH sought a new arrangement with HAMP to leverage its Medicaid MCO product and offer the IPH care model to the joint population of the current HAMP MCO product and IPH.
» After approval from HFS, the plan was enacted.
  › The two populations were combined.
  › The IPH came under administrative management of the health plan.
  › The Founders maintained the original attribution of patients under the ACE program.
» Change fatigue and lack of clarity on a defined future state from HFS caused many Founders with low enrollment to drop out of the IPH.

The remaining Founders with the highest enrollment still value the partnership and benefits of shared financial risk while awaiting additional details from Illinois.
III. IPH Current State
A Provider/Plan Partnership

The new partnership between HAMP and the IPH allowed each entity to leverage its strengths in managing the Medicaid population.

**HAMP**
- Focused on health plan administration:
  - Managed enrollment
  - Paid claims
  - Maintained provider file
  - Created marketing material and maintained website
  - Provided infrastructure support for care management services
  - Conducted central performance reporting

**Founders**
- Focused on improved care delivery and care coordination:
  - Delivered care under the IPH care model, including PCMH comes competencies
  - Maintained patient-centered, team-based care model
  - Conducted local performance reporting and management
  - Continued to build relationships with social services and local community resources
The story of the IPH offers many lessons learned for organizations considering the development of an ACO or similar value-based delivery model.

Beware of Regulatory Changes
Programs subject to legislative or other regulatory changes can be difficult to navigate unless programs are intentionally built with flexibility.

Value Organizational Partnerships
- In spite of the specific environmental challenges for IPH, collaboration between providers still offers opportunities to:
  - Share infrastructure costs.
  - Share clinical and operational best practices as organizations assume risk.
  - Spread financial risk.
  - Collaborate and exchange information on shared populations.
- Collaborations between providers and health plans allow each entity to focus on its strengths and form stronger overall organizations.

Developing a flexible and realistic approach and model will further ensure success in today’s value-based environment.
Questions & Discussion

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about ECG

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