

ILLINOIS STATE PROFILE

A. Program Description

Overview

As part of its state Medicaid reform law, signed in July 2012, Illinois has committed to ensuring that at least 50 percent of Medicaid beneficiaries are enrolled in a care coordination program no later than January 1, 2015. To achieve this goal, Illinois has adopted a two-year care coordination roll-out plan, overseen by the Department of Healthcare and Family Services (HFS). A critical element of this plan is launching the Care Coordination Innovations Project, through which the state has awarded a three-year contract to six regional Care Coordination Entities (CCEs) to coordinate services for adult Medicaid beneficiaries with complex health needs, with a particular focus on those with mental health and substance use disorders.

A CCE is a new formal network of pre-existing community-based providers. The providers composing the CCE vary but may include local hospitals, mental health providers, substance abuse service providers, federally qualified health centers (FQHCs), public health departments, mental health departments, pharmacy chains, and housing and social service agencies. The individual members of the CCE are bound together through a formal agreement and linked to each other through a newly developed care coordination component. The structure of this coordination component differs by CCE but generally consists of a team of care coordination professionals who work directly with clients, linking them to the services available through the CCE network. The care coordination team, which is employed by the CCE, not by any individual provider member, is the mechanism through which the individual provider organizations collaborate.

Financing

Illinois has not altered the provider payment model for this initiative; CCE providers of Medicaid services continue to be reimbursed through a fee-for-service arrangement. The CCEs do, however, receive a per-member per-month (PMPM) coordination fee to provide in-person care coordination services to clients.¹ The PMPM is supported through a mix of state and federal Medicaid funds. The CCEs have the flexibility to use the PMPM to cover costs of their choosing, although they use the fee primarily to cover costs associated with care coordination services. The state hopes that this flexible approach will incentivize the CCEs to find the most cost-effective way to improve care while reducing overall costs, with particular attention to costs associated with hospitalizations and emergency department use.

¹ The amount of the PMPM is not publicly available.

Goals

Although the state is moving toward mandatory managed care, it believes that the telephonic coordination model that managed care organizations (MCOs) often use is not effective in reaching and engaging individuals with complex medical needs. This is particularly true of those with serious behavioral health issues, who are often hard to engage and remain isolated from health and social systems. This CCE model is based on the idea that local community-based organizations, which understand the needs of the local client base and are knowledgeable about local resources, are best situated to find and engage these hard-to-reach clients. The initiative is testing provider interest in and capacity to implement models of care delivery and coordination beyond the traditional MCO model. State officials do not wish to run the CCE program, however. Instead, they view the state as a venture capitalist that provides only an initial investment to establish the CCEs, including a capped auto-enrolled number of clients (between 1,000 and 1,500 per CCE), agency support in developing the necessary legal contracts, and provision of Medicaid claims data for quality monitoring.² Long-term expansion and survival depends on the CCEs' ability to perfect and market their care coordination services to the larger state MCOs. The state believes that the MCOs will purchase these services if the CCEs can demonstrate associated long-term cost savings.

State Context

Illinois is working to reform its health care system into one that is more patient centered and focused on outcomes, access, and safety. State law requires that 50 percent of Medicaid beneficiaries, or about 1.8 million people, be in "risk-based care coordination" by January 1, 2015. Illinois intends to achieve this goal through various initiatives beyond the CCE program. These include its submission of a State Plan Amendment to Section 2703 (part of the Affordable Care Act) of the health home demonstration option for persons with chronic conditions; its care integration model for Medicare-Medicaid dual-eligible beneficiaries; and the recently established Affordable Care Entities, which will serve the expanded Medicaid population. State officials believe that if these CCE models prove effective, they can be integrated into the broader efforts.

Partnership Structure

HFS is the sole state agency responsible for CCE oversight; there is little formal collaboration with other state agencies regarding the CCE program. Instead, the state has encouraged partnerships between various private and government entities at the local level. This review focused on two CCEs as illustrative examples: My Health Care Coordination (MHCC), which began operations in September 2013 and covers five

² The state uses an algorithm that auto-enrolls the most expensive Medicaid beneficiaries to the CCEs, including a large proportion who are homeless. Individuals dually eligible for Medicare and Medicaid are ineligible for CCE enrollment.

downstate counties; and the Chicago-based Together4Health (T4H), operational as of December 2013.

MHCC is led by the Macon County Mental Health Board. It includes six other core collaborators: two community hospitals, an FQHC, a certified mental health and substance abuse service provider, the Decatur Housing Authority, and the Macon County Health Department. According to the stakeholders we interviewed, the development of this CCE grew out of a sense of shared accountability for the well-being of community members. The partnership includes all of the major health and service institutions in the region; although there is a formal and binding memorandum of understanding, the CCE is governed more informally through the existing relationships between member organizations.

T4H is led by Heartland Health Outreach (HHO), the health care arm of Heartland Alliance, a private non-profit provider of health and social services for the poor. Hoping to impact the transformation of the broader safety net system, HHO incorporated a diverse range of health and social service providers into the CCE, many of which had never worked together previously. T4H consists of 34 different entities, including hospitals, primary care physicians, a pharmacy chain, mental health providers, substance abuse and detoxification facilities, and various social and housing service providers. To join the CCE, organizations must make an initial capital contribution, thus transforming them into invested owners. T4H is governed by a representative board of managers that includes the various executives of the 34 owner organizations.

B. Coordination or Integration with Physical Health

Coordination Mechanism and Financing

Both T4H and MHCC have based their care coordination structure on the health home model; the state intends to pursue the Section 2703 health homes option, and thus has encouraged applicants to meet the related requirements. The composition and structure of the care coordination teams for these two CCEs are somewhat similar. Both have assembled a care coordination team of 15-20 individuals. These include mental health care coordinators, community health workers, and registered nurses at T4H; and care coordinators (who are registered nurses) and community navigators at MHCC. Clients are assigned to the appropriate team members based on level of need. Following a comprehensive needs assessment, the team develops a care plan and begins to work with clients, helping them connect with a range of available services and resources by relying heavily on the CCE provider network. The CCE teams are mobile; care team members meet clients out in the community and, when necessary, work out of provider offices. The state uses an algorithm to auto-assign the most complex clients to the CCEs. In addition, many of them are homeless and isolated from health and social service systems, so care coordination staff spend a significant amount of time searching for clients in the community; knocking on the doors of relatives and neighbors; and checking homeless shelters, local jails, food pantries, churches, and

other places frequented by this population. For this reason, the MHCC team in particular emphasized the importance of assembling a care team consisting of individuals with roots in the local community.

Coordinated Services and Stakeholder Interactions

The CCE program has not altered the landscape for providing Medicaid services, which still are reimbursed through a fee-for-service arrangement.³ CCE enrollees have access to all health services covered by Medicaid. Each CCE network includes providers of physical, mental, and substance abuse services, as required by the state. The diverse range of partners required for inclusion in the CCE ensures that a broad range of services are available through the CCE network, including comprehensive primary care, specialty care, inpatient care, emergency and crisis services, medication management, assertive community treatment services, case management, psychosocial rehabilitation, and detoxification services. The CCE model, which introduces a care coordination team that connects the various provider organizations, does not necessarily alter the level of direct interaction between providers. Rather, this model aims at providers becoming more informed about their clients as a result of the care coordination component.

C. Coordination or Integration with Housing or Other Social Services

Coordination Mechanism and Financing

The CCE initiative does not introduce a new or distinct housing program, nor does it provide new funding to support the use of any housing-related services. State officials strongly encouraged the inclusion of housing support-related providers in the CCE, although they did not make it a requirement. In theory, CCEs could use their PMPM funds to cover some of these non-Medicaid-reimbursable services; however, until CCEs further perfect their model, increase enrollment, and scale to efficiency, it is unlikely that such coverage will be possible. (The two CCEs we visited are not using PMPM funds directly for housing supports.) Instead, CCEs rely on their networks to connect clients with existing housing services, subsidies, and supports, which are often scarce. The lack of housing is a significant challenge for CCEs, since a large proportion of clients are homeless or at risk of being homeless. For social service and housing providers, whose services are not Medicaid-reimbursable or covered by the CCE's PMPM fee, involvement in the CCE is a significant investment. For these providers, being included is part of a long-term strategy to be represented in an evolving service system.

³ During an open enrollment period, Medicaid members must contact the Illinois Client Enrollment Broker to enroll in either a CCE or in one of the many managed care options. The state auto-enrolls those who do not contact the Broker in an MCO or CCE. Individuals who select to enroll or are auto-enrolled with a CCE are not served by an MCO. The state pays all services, using a fee-for-service arrangement.

Coordinated Services and Stakeholder Interactions

Although the CCE initiative provides no new housing services or resources, clients enrolled in a CCE work with a care coordination team that assesses and attempts to address such needs. Recognizing that the CCE population would have significant housing needs, both MHCC and T4H ensured that their teams included staff with experience in providing supportive housing. Through connections with housing-related partners, team members are able to link clients to scarce available resources. The T4H network, for example, includes several providers who manage housing units tied to Chicago's centralized referral system. Using this system, T4H care coordinators who have clients with housing needs are able to efficiently determine whether there are housing opportunities. MHCC similarly relies on its network to access available housing units for clients, including supportive housing properties and group homes managed by several core collaborators.

D. Key Perceptions and Lessons Learned for Implementing the Care Coordination Strategy

All stakeholders viewed the in-person care coordination component as critical to improving care for individuals with behavioral health conditions. State officials firmly believe that improved outcomes for the target population require localized care coordination that only community-based providers can achieve. Providers noted that the coordinators are valuable because they provide important information about their clients, including any home-related barriers to care, whether they are seeking needed and prescribed health care services at other facilities or taking prescription medication prescribed by other providers, and whether they are being connected to any needed social services. Care coordination team members can also take the time to help educate clients about their conditions and prescribed treatments. Consumers had positive perceptions of the CEE teams, describing their relationship as a partnership but emphasizing the importance of their being willing to develop a relationship with their care coordinator.

CCE implementation required intense technical assistance from the state. States should not overestimate the capacity of community-based organizations to develop the necessary infrastructure associated with a new entity (for example, legal arrangements, contracts, and data agreements). Those involved viewed direct communication with state Medicaid staff as critical to getting the CCEs off the ground and understanding how to operate within the confines of Medicaid rules and regulations. State officials emphasized that significant staff time and resources were devoted to providing technical assistance to the CCEs during the roll-out period. Staff associated with the CCEs noted the importance of having access to a dedicated liaison at the Medicaid agency.

Lack of a shared electronic health record (EHR) system or client database has been a significant limitation for CCEs. Although the teams maintain a system for

tracking their care coordination efforts, such as encounters and referrals, neither CCE visited for this review had a system fully integrated with the systems of the individual CCE provider members. Not having a single system limits communication between care coordination team members and the staff of the various providers, which creates barriers to efficient coordination and communication. Despite these limitations, neither CCE intended to develop a single EHR platform, as the costs and efforts required would be significant.

Although uniquely arranged and potentially more efficient, the new care coordination teams must avoid competing with or duplicating existing case management services. Many CCE clients have pre-established relationships with case managers at other organizations, including those that are part of the CCE network. This can create confusion (for both consumers and provider staff) regarding roles and responsibilities, as well as fears of service duplication. Care coordination team members devote considerable time to establishing a relationship with these other case management teams and work to ease any sense of competition. The CCE teams are structured to do more than the typical case manager, including coordinating a broader range of services, providing health-related education and motivational support, and driving and accompanying clients to appointments. Care team members associated with both CCEs emphasized that they do not compete or attempt to alter existing relationships between clients and case managers; instead, they offer to support the case managers, who are often far more limited in what they can do for a client.

Sustainability is challenged by the partial-risk structure and limited state support. A consequence of the state's hands-off approach is that providers feel uncertain about the CCEs' future. The state has indicated that no further auto-enrollment will occur, believing that the limited number of enrolled clients allows the CCEs to focus on developing a localized and cost-effective model of care coordination. State officials report that they will view this initiative as a success if the CCEs are able to market their model to the state MCOs, which are serving a larger population at full risk, or to the newly established affordable care organizations. These entities often lack the capacity to provide the level of care coordination that the CCEs focus on developing, thus creating an opportunity for partnership. However, there are two reasons providers may hesitate to commit additional resources toward model expansion: (1) the CCEs are only at "partial-risk" (at-risk only for the care coordination services); and (2) individual providers do not rely on the CCE to operate (all providers would continue to serve clients if the CCE fails).

Effective care coordination teams must have the ability to help enrollees access a broad and diverse range of services. Both CCEs devoted significant time to constructing the right kind of care coordination team and emphasized that staff must be equipped not only to coordinate a broad range of health and social services, but also must be skilled in engagement. A large number of CCE enrollees are homeless or have

been isolated from safety net systems, and staff must be able and willing to be flexible and creative in developing engagement strategies. To be effective, care coordination teams have established relationships with a wide range of other community entities, including shelters, churches, and the local criminal justice system. CCE staff thus emphasized the value of assembling a care team embedded in the local community.

UNDERSTANDING INNOVATIVE STATE SYSTEMS THAT SUPPORT COORDINATED SERVICES FOR INDIVIDUALS WITH MENTAL AND SUBSTANCE USE DISORDERS

Reports Available

Improving the Coordination of Services for Adults with Mental Health and Substance Use Disorders: Profiles for Four State Medicaid Initiatives

HTML <http://aspe.hhs.gov/report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives>

PDF <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-profiles-four-state-medicaid-initiatives>

Illinois Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Louisiana Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Massachusetts Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

Tennessee Profile only -- <http://aspe.hhs.gov/pdf-report/improving-coordination-services-adults-mental-health-and-substance-use-disorders-illinois-state-profile>

State Strategies for Coordinating Medicaid Services and Housing for Adults with Behavioral Health Conditions

HTML <http://aspe.hhs.gov/basic-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions>

PDF <http://aspe.hhs.gov/pdf-report/state-strategies-coordinating-medicaid-services-and-housing-adults-behavioral-health-conditions>

State Strategies for Improving Provider Collaboration and Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions

HTML <http://aspe.hhs.gov/basic-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions>

PDF <http://aspe.hhs.gov/pdf-report/state-strategies-improving-provider-collaboration-and-care-coordination-medicaid-beneficiaries-behavioral-health-conditions>