

# Illinois Health Connect Your Healthcare Plus™



## CASE STATEMENT

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**Illinois Academy of Family Physicians, 2010  
The Robert Graham Center, 2010**

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Glossary of Common Abbreviations:

AHS:	Automated Health Systems
DM:	Disease management
ED:	Emergency department
HFS:	Illinois Department of Healthcare and Family Services
IHC:	Illinois Health Connect
MCO:	Managed care organization
MHS:	McKesson Health Solutions
PCCM:	Primary care case management
PCP:	Primary care provider
YHP:	Your Healthcare Plus

## EXECUTIVE SUMMARY

The rise of primary care case management (PCCM) programs over the last two decades can be directly attributed to rising healthcare costs and the increasing burden of chronic disease in the United States. In an effort to rein in Medicaid spending, states have increasingly looked towards new models of healthcare delivery that emphasize coordination and efficiency in order to drive down inappropriate spending and improve healthcare outcomes. Recent trends in the American fiscal and legislative landscape have added new urgency to the search for improved delivery platforms covering the Medicaid population. With the economic recession, states are more pressed than ever to be efficient healthcare spenders, and with the passage of the federal Patient Protection and Affordable Care Act in March 2010, increased enrollment in publicly subsidized coverage plans will almost certainly add new strain to state budgets.

The 1990s saw rapid increases in Medicaid expenditures in many states. Enrollment swelled as rising private insurance premiums became costly for many individuals. Furthermore, issues surrounding Medicaid access and increasing chronic disease burdens in this population drove increases in costly tertiary care spending. The unsustainable trajectory of these trends has garnered the attention of governors, state legislators and national policy makers alike.

In 2006 the state of Illinois implemented two programs, Illinois Health Connect and Your Healthcare Plus, in an effort to deal with these issues. In a period lacking federal input on healthcare reform, Illinois and others independently sought policy solutions from the state level. Now serving 1.9 million of Illinois' Medicaid beneficiaries (66% of all eligible and 15% of the total state population), these programs employ novel methodologies designed to control cost while providing the highest possible care to the underserved communities of the state.

Understanding the importance of patient decision-making, these programs emphasize behavioral modification through coverage of preventive services, social outreach, and community and medical home partnerships. With strong emphases on disease management and redesigned payment mechanisms that reward care coordination, case management and quality healthcare for patients over high volume, these programs have met with initial success in terms of patient/provider satisfaction, improved quality metrics, and early cost savings to the state.

The legislative environment in the state of Illinois is currently favorable towards innovative health reform (Illinois Health Connect and Your Healthcare Plus were implemented by gubernatorial mandate), making a formal assessment of new delivery platforms important to state legislators and policy makers.

A detailed understanding of the competencies and efficiencies of these programs will provide evidence for how Illinois can best plan and pay for the future of its healthcare delivery services. As states across the country engage in similar evaluations of their platforms, Illinois has the opportunity to better understand how to maximize its PCCM and disease management (DM) services and bend the cost curve.

This case statement serves as a primer on Illinois Health Connect and Your Healthcare Plus. It describes these programs, their early achievements and the current state environment in which they exist. It then compares them to several model projects occurring in other states.

## **THE EVOLUTION OF PRIMARY CARE CASE MANAGEMENT (PCCM) AND DISEASE MANAGEMENT (DM) PROGRAMS**

### **Primary Care Case Management**

Today, 71% (or 33 million) of Medicaid beneficiaries are enrolled in managed care, an increase from 56% in 1999<sup>1</sup> and accounting for more than half of enrollees in 46 states and the District of Columbia. Given shrinking state budgets<sup>2</sup> and growth in Medicaid spending<sup>3</sup>, legislatures have relied on managed care organizations (MCOs) to rein in cost. States use a variety of managed care arrangements, but two forms have been dominant – risk-based MCOs and primary care case management (PCCM) programs. Risk-based MCOs receive a fixed per member per month fee in exchange for assuming the financial risk for health care delivery. In contrast, the state Medicaid agency acts as the health plan in PCCM programs, purchasing health care services from participating providers.

In the late 1990s, commercial MCOs started withdrawing from the Medicaid managed care market citing poor reimbursements and shrinking profits<sup>4 5</sup>, leading to the expansion of PCCM programs. There was also difficulty with identifying measureable quality and health outcomes from MCOs, whereas PCCMs were more successful in reporting outcome improvements. As of 2008, 6.6 million Medicaid beneficiaries were enrolled in one of the 35 PCCM programs in 29 states<sup>6</sup>.

PCCM programs initially developed in the mid-1980s with primary care providers (PCPs) assuming responsibility for providing and monitoring care in exchange for a monthly case management fee in addition to fee-for-service payments. Several factors contributed to their expansion in Medicaid managed care. First, states wanted to expand access to care, hoping that case management fees would entice providers to participate in Medicaid. Medicaid agencies also wanted to link patients with medical homes to reduce inappropriate emergency and specialty use. Finally, PCCM was better suited for certain geographies such as rural areas given that MCOs had difficulty staying financially viable in areas of low population density<sup>7</sup>.

Wanting to further improve quality and decrease costs, states began enhancing basic PCCM programs. To support more sophisticated care coordination, Medicaid agencies increased care management fees and offered bonus payments to providers who

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<sup>1</sup> National summary of Medicaid managed care programs and enrollment as of June 30, 2008 [Internet]. Centers for Medicare & Medicaid Services. [accessed 2010 May 22]. Available from: <http://146.123.140.205/MedicaidDataSourcesGenInfo/downloads/08Trends508.pdf>.

<sup>2</sup> The fiscal survey of states [Internet]. National Governors Association. 2009 [accessed 2010 May 22]. Available from: <http://www.nga.org/Files/pdf/FSS0906.pdf>.

<sup>3</sup> Holahan J, Yemane A, Rousseau D. Medicaid expenditures increased by 5.3% in 2007, led by acute care spending growth. The Kaiser Family Foundation. 2009.

<sup>4</sup> Rawlings

<sup>5</sup> Long SK, Yemane Alshadye. Commercial plans in Medicaid managed care: Understanding who stays and who leaves. *Health Aff (Millwood)*. 2005; 24(4): 1084-1094.

<sup>6</sup> Medicaid and managed care: Key data, trends, and issues. Kaiser Family Foundation. 2010 February.

<sup>7</sup> Rawlings-Sekunda J, Curtis D, Kay N. Emerging practices in Medicaid primary care case management programs [Internet]. National Academy for State Health Policy. 2001 [accessed 2010 May 21]. Available from: <http://aspe.hhs.gov/health/reports/pccm/chapt2.htm#top>.

were able to demonstrate higher quality and lower costs in the form of fewer unnecessary emergency department (ED) visits and hospitalizations.

## **Disease Management**

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Chronic disease afflicts 30% of Medicaid beneficiaries (or 14.4 million nationally), negatively impacting quality of life and productivity and accounting for 83% of Medicaid spending<sup>8</sup>. Prior research has confirmed that patients with more chronic conditions have higher costs though increased spending typically does not translate into better outcomes<sup>9</sup>. DM programs were developed to adapt the Chronic Care Model to delivery structures historically designed to respond to acute illness, improve quality, and decrease costs associated with high utilization populations<sup>10</sup>.

DM programs affiliated with PCCM programs expanded in the late 1990s in response to the growing numbers of eligible members, rising cost of medical care, desire to better coordinate care, and need to increase adherence to evidence-based guidelines<sup>11</sup>. Such programs tend to focus on high-risk populations and those with specific chronic conditions such as diabetes mellitus, asthma, and congestive heart failure.

## **HISTORY OF ILLINOIS HEALTH CONNECT AND YOUR HEALTHCARE PLUS**

Illinois Health Connect (IHC) and Your Healthcare Plus (YHP) emerged in the mid 2000's as a solution to rising costs and access concerns surrounding Illinois' Medicaid population. Over-utilization, insufficient care coordination, and pediatric access issues were also cited as rationale for invoking a strategic policy change. Policy makers had advocated for expansion of MCOs since the 1990s in lieu of rising costs. Also, a pivotal lawsuit filed against the state of Illinois in 1995 alleged (and ultimately upheld) that poor reimbursement was preventing patient access to care. In this environment, PCCM programs came into vogue as a means of controlling costs.

## **Memisovski and All Kids**

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The need for change was crystallized in August 2004 when a decision in *Memisovski v. Maram* ruled in favor of the plaintiff, finding the State of Illinois in violation of federal law 42 U.S.C. § 1396a(a)(30)(A). The provision ensures Medicaid recipients have access to pediatric care to the same extent as the general population. The

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<sup>8</sup> Arora R, Boehm J, Chimento L, Moldawer L, Tsien C. Designing and implementing Medicaid disease and care management programs: A user's guide [Internet]. AHRQ Publication No. 07(08)-0063. 2008 [accessed 2010 May 20]; Available from: <http://www.ahrq.gov/qual/medicaidmgmt/medicaidmgmt.pdf>.

<sup>9</sup> Williams C. Medicaid disease management: Issues and promises. Kaiser Family Foundation. 2004 September.

<sup>10</sup> Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: Translating evidence into action. *Health Aff (Millwood)*. 2001; 20(6): 64-78.

<sup>11</sup> Rosenman MB, Homes AN, Ackermann RT, Murray MD, Doebbeling C, Katz B, Li J, Zillich A, Prescott VM, Downs SM, Inui TS. The Indiana Chronic Disease Management Program. *Milbank Q*. 2006; 84(1): 135-163.

plaintiff contended that Medicaid in Illinois reimbursed at rates that provided significant barriers in access.

In the wake of this judicial finding, the Governor implemented the All Kids program, a top down redesign of vulnerable pediatric coverage. Using state funds to complement existing Medicaid and SCHIP awards, *All Kids became the nation's first pediatric universal coverage system*. By subsidizing insurance for vulnerable children, the state aimed to improve health outcomes, promote school performance, and increase family productivity that would otherwise be negatively affected through poorer health. Understanding the importance of patient decision-making, these programs emphasize behavioral modification through coverage of preventive services, social outreach and community partnership.

The creation of All Kids generated energy for lawmakers to promote PCCM and DM programs - Illinois Health Connect and Your Healthcare Plus, respectively - for the state's vulnerable adults. Advisory committee meetings attended by stakeholders (providers, clinics, insurers, government administrators, hospitals, etc.) informed the implementation and expansion of both programs.

### **Illinois Health Connect (IHC)**

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In late 2006 IHC was implemented as a means of extending the PCCM model from the success of All Kids to a broader swath of state Medicaid beneficiaries. Now enrolling approximately 1.9 million Illinois citizens, IHC has emphasized patient contact with a PCP through medical homes. With regular contact and continuity of chronic disease care occurring in this setting, the model aims to simultaneously promote preventive services and reduce redundancy. In 2006, the Illinois Department of Healthcare and Family Services (HFS) (the state agency responsible for administering the Medicaid program) contracted with Automated Health Systems (AHS) to administer IHC. In 2007, mandatory enrollment in PCCM swept from north to south across the state, successfully enrolling 1.6 million patients. IHC annually reports on a number of internal quality measures and provider and patient satisfaction indicators. In 2009:

- 76.1% of in network providers felt that IHC is well administered and responsive to provider questions<sup>12</sup>
- More than 90% of IHC participating providers received bonus payments in 2008<sup>13</sup>
- More than 95% of patients (urban and rural) rated their experience with IHC as satisfactory or very satisfactory<sup>14</sup>

Provider bonus incentives are based on performance in various categories including developmental screening, diabetes core measures and adherence to prevention guidelines (e.g. mammography and vaccinations). IHC further provides web portal access to its

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<sup>12</sup> Summary of Illinois Health Connect Provider Satisfaction Survey Results [Internet]. Illinois Health Connect. 2009 [accessed 2010 June 7]; Available from: [ilpccm.com/files/ProviderImportantNotices/IHC\\_ProviderSurveyResults.pdf](http://ilpccm.com/files/ProviderImportantNotices/IHC_ProviderSurveyResults.pdf).

<sup>13</sup> Parker J. Addressing healthcare needs of the ABD Medicaid population [Internet]. Illinois Department of Healthcare and Family Services. [accessed 2010 June 7]; Available from: [www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20ABD%20Presentation.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20ABD%20Presentation.pdf).

<sup>14</sup> Enrollee Satisfaction Survey. Illinois Health Connect. 2010.



providers for feedback, questions and monitoring of specific patient values for quality improvement.

## **Your Healthcare Plus (YHP)**

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With an invigorated commitment to cover vulnerable populations, YHP was launched in July 2006, targeting some of the highest users of the state's Medicaid system. YHP currently covers 260,000 individuals including adults with disabilities who have chronic or complex health issues, children and adults in the Family Health population with persistent asthma, high-frequency ED users in the Family Health population, and individuals in the elderly and physical disability waiver programs. The DM program focus includes education, member and provider communications, and outreach to providers as key features of the program. The majority of YHP patients are also covered by IHC. In fact, only some 11,000 institutionalized patients (such as nursing home residents) are under YHP exclusively.

YHP is administered by McKesson Health Solutions (MHS), which is contracted by HFS. During its first 3 years of operation, McKesson has reported a \$307 million savings to Illinois taxpayers<sup>15</sup>. Among its key clinical achievements:

- 15.5% increase in annual influenza vaccination rate
- 22% increase in pneumococcal vaccination rates
- 20% increase in patients having an asthma action plan
- 7% increase in annual dilated retinal exams for persons with diabetes
- 33% decreased hospital utilization for persons with persistent asthma
- 5% decreased hospital utilization for adults with disabilities<sup>16</sup>

## **Today**

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Currently, a challenging economy has directed lawmakers across the country towards balancing state budgets. Given the passage of recent healthcare law, there is additional interest in making Medicaid spending more efficient. In Illinois, renewed attention has been paid to managed care, which is seen as a potential solution to reining in Medicaid costs.

There is enthusiasm to better understand how IHC and YHP have benefited the patients they serve and where and how savings have been garnered for the state. Both programs include ongoing, internal quality improvement and monitoring processes to better understand outcomes and how to drive additional efficiencies.

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<sup>15</sup> McKesson, Illinois Department of Healthcare and Family Services report \$169 million in net savings in program's third year [Internet]. 2010 May 19 [accessed 2010 July 7]; Available from: [www.mckesson.com/en\\_us/McKesson.com/About%2BUs/Newsroom/Press%2BReleases%2BArchives/2010/McKesson%252C%2BIllinois%2BDepartment%2Bof%2BHealthcare%2Band%2BFamily%2BServices%2BReport%2B%2524169%2B05-19-2010.html](http://www.mckesson.com/en_us/McKesson.com/About%2BUs/Newsroom/Press%2BReleases%2BArchives/2010/McKesson%252C%2BIllinois%2BDepartment%2Bof%2BHealthcare%2Band%2BFamily%2BServices%2BReport%2B%2524169%2B05-19-2010.html).

<sup>16</sup> McKesson, Illinois Department of Healthcare and Family Services report \$169 million in net savings in program's third year.



## PROGRAM DESCRIPTIONS

### Illinois Health Connect (IHC)

IHC is the Medicaid PCCM program of Illinois, which is overseen by HFS and administered by an external vendor - Automated Health Systems (AHS). The statewide, mandatory program for eligible HFS clients links Medicaid beneficiaries with medical homes, was started in July of 2006, and seeks to improve preventive services for patients.

Specifically, IHC aims to:

- Improve access to high quality medical care through the availability of provider networks and expansion of providers
- Ensure clients have a medical home with a PCP<sup>17</sup>
- Ensure clients receive necessary preventive and primary care
- Reduce inappropriate ED visits and hospitalizations

IHC services for patients include: enrolling clients into medical homes, providing clients with information on their health plan choices to assist them with their PCP selection, processing requests for PCP changes, maintaining a hotline and website to help clients locate providers (including specialists when needed), operating an after-hours nurse consultation helpline, and reaching out to children and adults who have not had preventive visits based on HFS claims data and connecting the patients with their PCPs by assisting with scheduling appointments. In addition, IHC provides enrollment and education services for PCPs including: recruiting new primary care and specialty providers and maintaining the provider network, operating a hotline and website for providers, answering questions regarding provider responsibilities, and providing feedback for providers – including panel rosters, provider profile reports, claims history reports, and Provider Service Representatives and Quality Assurance Nurses (who work with providers and their staff on a face-to-face basis to help with program updates, program implementation and quality improvement efforts within their offices).

Approximately 1.9 million of the 2.5 million total patients enrolled in HFS Medical Programs are required to enroll in IHC although clients in certain counties<sup>18</sup> have the option of participating in IHC or one of three MCOs. Eligible populations include children in All Kids, parents in the FamilyCare Program, adults with disabilities, and the elderly (age 65 and older) although those with dual eligibility with Medicare are ineligible. Certain populations are excluded from the requirement<sup>19</sup>. General

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<sup>17</sup> Family physicians, internists, and pediatricians are considered primary care.

<sup>18</sup> Clients living in Adams, Brown, Cook, Henry, Jackson, Madison, Mercer, Perry, Pike, Randolph, Rock Island, St.Clair, Scott, Washington, and Williamson Counties can enroll in either IHC or one of the MCOs. Currently, 190,000 clients are enrolled in MCOs.

<sup>19</sup> Excluded populations include Medicare beneficiaries, children under age 21 who get supplemental security income, children in foster care and children who get subsidized guardianship or adoption assistance from the Department of Children and Family Services, children under age 21 who are blind or who have a disability, those living in nursing facilities, American Indians, Alaska natives, individuals with spend-down, individuals in the breast and cervical cancer program, those in the presumptive eligibility programs, refugees, some patients home and community-based services, individuals in Community

practitioners, general internists, general pediatricians, family physicians, OB/GYNs, and other specialists can participate in the program. Other eligible providers include federally qualified health centers (FQHCs), rural health centers, Cook County Bureau of Health Services clinics, certified local health departments, and school-based clinics<sup>20</sup>. In 2009, 5442 medical homes were enrolled in IHC, providing the capacity to see 5.3 million clients. Participating providers are expected to provide direct access to enrollees 24 hours per day, seven days per week, maintain a minimum number of weekly office hours<sup>21</sup>, provide timely appointment availability based on specific criteria<sup>22</sup>, provide and coordinate maternal and child health services, and agree to institute an action plan for enrollees with chronic diseases.

In exchange for these services, PCPs receive a monthly care management fee per person (\$2 per member per month (PMPM) for each child under age 21, \$3 PMPM for each adult, and \$4 PMPM for each disabled or elderly enrollee) on top of fee for service (FFS) payments. PCPs also automatically qualify for the Maternal and Child Health reimbursement rates. In 2009, HFS distributed \$2.8 million in annual bonus payments of at least \$25 per patient to providers meeting quality criteria under the 2008 Bonus program:

- 68.6% of children receiving designated vaccinations by 24 months of age
- Children receiving developmental screening (with age specific criteria and benchmarks)
- Patients with persistent asthma who fill an asthma controller medication prescription (with age specific criteria and benchmarks)
- 79.6% of diabetics aged 18-65 with at least one hemoglobin A1c (HbA1c) annually
- 50.1% of women aged 40-69 with a mammogram in the last two years

### **Your Healthcare Plus (YHP)**

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Started in July of 2006, YHP is the voluntary Medicaid DM program that is overseen by HFS, administered by McKesson Health Solutions and is designed to improve care for patients with chronic illnesses. In addition to an emphasis on behavioral health, the YHP program distinguishes itself from standard DM programs in its

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Integrated Living Arrangements, children under age 21 whose care is managed by the Division of Specialized Care for Children at the University of Illinois, Chicago, those in the Program for All-Inclusive Care for the Elderly, individuals with high level third party liability or private insurance, and those in the limited benefits programs with no other medical eligibility – Illinois Healthy Women, All Kids / FamilyCare Rebate, Illinois Care Rx, transitional assistance, medical assistance only, hospice, and sexual assault, renal, and hemophilia programs.

<sup>20</sup> Illinois Health Connect fact sheet [Internet]. 2009 [accessed 2010 May 20]. Available from: [http://www.hfs.illinois.gov/assets/pccm\\_fs.pdf](http://www.hfs.illinois.gov/assets/pccm_fs.pdf).

\* Family physicians, internists and pediatricians are considered primary care.

<sup>21</sup> 24 hours per week for solos practitioners and 32 hours per week for group practices

<sup>22</sup> IHC providers are required to make preventive care available within 5 weeks of request (or 2 weeks for infants less than 6 months), urgent care appointments within 24 hours, non-serious complaints within 3 weeks, and ED or hospital follow ups within 7 days of discharge.

integration with both the communities in which patients reside and with medical homes. Specifically, YHP aims to:

- Improve the health outcomes of participants
- Reduce avoidable costs and unnecessary ED and inpatient utilization
- Improve care coordination
- Increase member adherence to treatment plans
- Improve self-management knowledge and skills
- Improve adherence to national, evidence-based clinical practice guidelines
- Provide tools and office support that improves communication across all team members

Four Medicaid populations totaling 260,000 are eligible for voluntary participation in YHP: 1) adults with disabilities who have chronic conditions including asthma, diabetes mellitus, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), congestive heart failure (CHF), schizophrenia and depression (117,000), 2) children and adults in the Family Health population with persistent asthma (110,000), 3) high frequency ED utilizers<sup>23</sup> (23,000), and 4) elderly and physically disabled individuals in waiver programs (8,500). Individuals can opt out YHP. Those with dual eligibility for Medicare are ineligible.

Once clients are identified as eligible for the YHP program, HFS uses IHC medical home assignment data to identify PCPs from whom eligible patients receive care. Providers receive lists of their program eligible patients, claims-based clinical metric data and invitations to work with YHP staff to develop care plans for patients. YHP staff reach out to members to inform them about the program services and assess their willingness to participate.

YHP uses a multi-disciplinary approach, tailoring care to individuals, and promoting aspects of the Chronic Care Model. First, YHP participants are stratified into risk categories using two years of historical claims data and predictive modeling tools. High-risk patients (approximately 4% of YHP eligible members) receive face-to-face home visits to promote adherence to treatment plans and care coordination of resources. Moderate risk patients receive telephone or face-to-face counseling and educational support, while low risk patients receive educational mailings and have access to call the program at any time. YHP social workers are available to address identified barriers and help patients connect with community resources. YHP behavioral health specialists connect participants with community mental health centers, and YHP pharmacists review complex medication regimes. Members recently discharged from the hospital also receive a nurse-led care transition intervention designed to ensure medications are filled and that directions are understood, teach about warning signs, facilitate appointment making and address barriers to appropriate care. While nurses support a large core of the program, the YHP staff model is comprised of other team members designed to work together collaboratively. Other team members include lay community educators, social workers, and pharmacists. Furthermore, lay community educators identify at risk patients

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<sup>23</sup> Frequent ED users are defined as having more than 6 ED visits within a 12-month span, none of which resulted in an admission.

and provide outreach and peer-to-peer support to manage life challenges and provide support for healthier life styles.

YHP also provides direct support to physicians. In thirteen high volume FQHCs<sup>24</sup>, YHP health workers provide face-to-face care coordination, reminding patients of appointments, assessing barriers to keeping appointments, ensuring persons with asthma have action plans, and updating demographic information. Furthermore, physicians of YHP participants receive quarterly chronic care patient summaries with the status of selected clinical measures for those with asthma, diabetes mellitus, COPD, CAD, CHF, and depression. These reports also list the percentage of a provider's panel adhering to specific evidence-based guidelines. Chart reminders – one-page documents that address specific guideline gaps for individual patients – are delivered to physicians. In collaboration with the Illinois Academy of Family Physicians, YHP also provides continuing medical education courses focusing on the management of chronic diseases. Finally, YHP and IHC provide participating physicians with quarterly educational newsletters.

## **ENVIRONMENTAL CONSIDERATIONS**

The fiscal climate from 2008-2010, dominated by rising unemployment, threatened states' ability to provide for the social safety net and health of vulnerable populations. Preventing the erosion of the safety net has generated significant legislative debate, and new service delivery methodologies are being explored to deal with rising costs. Policy makers are moving towards system integration to aggressively manage chronic disease, reduce redundancy, and focus on community need in culturally competent ways with continuous feedback for self-improvement.

It is therefore notable that during this time period Illinois managed to increase its designated medical homes from 5,000 to 5,700 (a 14% increase), serving 1.3 million in 2008 to 1.9 million in 2010 (a 46% increase). In one south side of Chicago neighborhood alone, some 40% of the population is uninsured or dependent on public programs<sup>25</sup>. A statewide rollout of IHC and YHP has encouraged providers to sign up as medical homes where aspects of traditional high volume, FFS payments are replaced by incentives that reward prevention compliance and chronic DM. Notable achievements for these programs include:

- PCP payment increases from 50% to 70-80% of Medicare
- Improvement in ambulatory pediatric payment rates
- Specialty payment rate increases
- 30 day billing cycles
- Bonus payments for high performance
- Monthly care management fees
- Maternal and child health reimbursement rates

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<sup>24</sup> High-volume clinics typically have more than 600 YHP patients.

<sup>25</sup> A plan for the coordination of health care services for vulnerable pregnant women and children on Chicago's south side [Internet]. Health Management Associates. 2009 March [accessed 2010 June 7]; Available from: [www.healthmanagement.com/files/Comer%20Report-Final.pdf](http://www.healthmanagement.com/files/Comer%20Report-Final.pdf).

Additionally, in 2005 Illinois passed tort reform capping noneconomic medical damages to \$500,000<sup>26</sup>. Though later overturned in 2010 by the Illinois Supreme Court, its passage indicates Illinois' current favorable environment towards health reform. Later, in 2007 Illinois healthcare was further advanced when legislation made Illinois smoke free. The state and provider commitment towards these programs remains strong, likely given the continued focus to rein in unnecessary spending and improve quality and access.

The above measures must be understood within the context of state need. Of Illinois' population of 12.6 million, 23% are Medicaid eligible (2.9 million). YHP netted \$307 million in state savings over the first three years of the program. Much of this has been attributed to the deployment of numerous provider and community based resources that focus on chronic DM, engaging mental health disparities, partnering with community stakeholders and regulatory agencies and increasing care coordination. These elements are perceived to be critical to improving quality in vulnerable populations and controlling state costs. The Agency for Healthcare Research and Quality (AHRQ) supports these elements as fundamentally important to curbing unnecessary, redundant or costlier care<sup>27</sup>.

Budgetary constraints threaten the viability of these programs. In 2010, the National Association of Community Health Centers reported a 13% decrease in all health center payments from the previous year (across 36 states and the District of Columbia). The American Reinvestment and Recovery Act of 2009 was critical to curbing declining revenues by moving an unprecedented \$2 billion into community health centers (CHCs) and extending coverage to more than 2 million Americans. The Illinois FY2010 budget allocated only one-third of the state's total \$2 billion for All Kids and Medicaid. Members of the Illinois Primary Care Health Association fear that this was insufficient, suggesting it may lead to staff layoffs and reduced access at many CHCs across the state, which would endanger the health of the state's most vulnerable<sup>28</sup>.

Sustaining transformations in care delivery to promote health quality remains a challenge. A report by the Comer Foundation<sup>29</sup> cites that despite decent medical home penetration, ED over utilization in Chicago's south side is still prevalent. Future environmental challenges for the state will be centered around improving medical home capture and service delivery, improving access to specialty care through referral and rational service distribution and continuing to reassess primary care service and prevention guideline adherence.

The Illinois Medicaid program has successfully shepherded health care reform through the PCCM and DM programs. The Medicaid program was a purchaser of services before IHC and YHP were launched. Now, the Medicaid program is a manager

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<sup>26</sup> Norbut M. Illinois tort reform caps damages [Internet]. American Medical News. 2005 June [accessed 2010 June 7]; Available from: <http://www.ama-assn.org/amednews/2005/06/13/gvsc0613.htm>.

<sup>27</sup> VanLandeghem K, Brach C. Impact of primary care case management implementation on Medicaid and SCHIP. CHIRI Issue Brief No. 8. Rockville, MD: Agency for Healthcare Research and Quality. 2009 March; AHRQ Pub. No. 09-0020.

<sup>28</sup> Hayden J. The crisis: Field perspectives – Illinois [Internet]. National Association of Community Health Centers. 2010 [accessed 2010 June 7]. Available from: [www.nachc.org/magazine-article.cfm?MagazineArticleID=149](http://www.nachc.org/magazine-article.cfm?MagazineArticleID=149).

<sup>29</sup> A plan for the coordination of health care services for vulnerable pregnant women and children on Chicago's south side.



of population health, willing to innovate, promote change, and work with PCPs to support care improvement and hold them accountable.

Fiscal savings through both programs totaled over \$500 million for the past two years, about 4% savings<sup>30 31</sup>. Incorporating medical homes has been the centerpiece of the PCCM and DM programs. Program improvements have been coordinated with and through the primary care practices. Plans for further advancements in both programs should closely consider how to strengthen medical homes.

## CASE STUDIES FROM OTHER STATES

Like Illinois, Oklahoma, North Carolina, and Indiana have developed innovative programs to monitor costs and improve the quality of healthcare for Medicaid enrollees (Table 1). These states have recognized the importance of not only creating these programs but also evaluating them.

Table 1: Medicaid Primary Care Case Management and Disease Management Programs in Oklahoma, North Carolina, Indiana, and Illinois

State	Program	Program Type	Enrollment	Year
Oklahoma	SoonerCare Choice	PCCM	447,866 <sup>32</sup>	2010
	Health Management Program	DM	~ 4000 <sup>33</sup>	2009
North Carolina	Community Care of North Carolina & Carolina ACCESS	Combined PCCM and DM	1,113,717 <sup>34</sup>	2010
Indiana	Care Select	Combined PCCM and DM	72,966 <sup>35</sup>	2010
Illinois	Illinois Health Connect	PCCM	1,777,737 <sup>36</sup>	2010
	Your Healthcare Plus	DM	261,000	2010

<sup>30</sup> Colias M. Illinois credits program changes with \$300M Medicaid savings [Internet]. Chicago Business. 2010 April [accessed 2010 July 26]. Available from: <http://www.chicagobusiness.com/cgi-bin/news.pl?id=37995>.

<sup>31</sup> Arvantes J. Primary care initiatives help save state Medicaid program millions. AAFP News Now. 2010 July 21 [accessed 2010 July 26]. Available from: <http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20100721illinoismedicaid.html>.

<sup>32</sup> SoonerCare fast facts. Oklahoma Health Care Authority. 2010 May.

<sup>33</sup> Oklahoma Health Care Authority State fiscal year 2009 annual report. Oklahoma Health Care Authority. 2009.

<sup>34</sup> CCNC/CA Medicaid monthly enrollment report. North Carolina Medicaid. 2010 June.

<sup>35</sup> Personal communication with Natalie Angel. Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning. 2010 June 28.

<sup>36</sup> Total enrollment figures for participating MCOs [Internet]. Illinois Department of Healthcare and Family Services. 2010 June [accessed 2010 June 28]. Available from: [http://www.hfs.illinois.gov/managedcare/managedcare\\_enrollment.html](http://www.hfs.illinois.gov/managedcare/managedcare_enrollment.html).

## OKLAHOMA

### Background and Components

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Following a 72% increase in Medicaid expenditures between 1988 and 1992, the Oklahoma legislature created the Oklahoma Health Care Authority (OHCA) to implement Medicaid managed care, hoping the model would slow expenditure growth. In 1995, SoonerCare Plus was created, offering fully capitated services through five MCOs, which operated in three urban centers<sup>37</sup>. To serve rural communities, OHCA developed SoonerCare Choice in 1996, a partially capitated PCCM program that paid physicians 10% of enrollees' total predicted costs (averaging \$12 per enrollee per year).

Between 1999 and 2003, SoonerCare Plus struggled to survive. Enrollment of the high-need aged, blind, and disabled (ABD) populations into MCOs in 1999 and increases in Medicaid enrollment resulting from a sluggish economy in 2002 threatened the viability of the MCOs, forcing several to leave the market. Internal OHCA analyses indicating that SoonerCare Choice provided similar outcomes and satisfaction at lower costs compared to SoonerCare Plus led to OHCA's decision to replace MCOs with an expansion of their PCCM program in 2004<sup>38</sup>.

Following the extension of SoonerCare Choice into urban areas, OHCA further reformed Medicaid delivery by creating the Health Management Program in 2006 – a DM program designed and overseen by OHCA but operated by the Iowa Foundation for Medical Care that targets 5000 high-cost, high-need enrollees. Most recently, OHCA has sought to incentivize quality in SoonerCare Choice by replacing partial capitation with care coordination and pay-for-performance payments. In support of these programs, Oklahoma Medicaid reimbursement is relatively high (100% of Medicare in 2008).<sup>39</sup>

### Evaluations

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*Costs and Utilization:* Reports have concluded that SoonerCare Choice and the Health Management Program are succeeding at slowing the growth of Medicaid expenditures. A preliminary analysis by Mathematica indicated that the Health Management Program could produce a return on investment of as much as three to one in terms of savings by the third year of implementation<sup>40</sup>. A formal evaluation of SoonerCare between 1992-2008 demonstrated that Medicaid costs per member in Oklahoma were less than the national average from 1996-2005. Medicaid expenditures in the state accounted for 6.5% of the budget in 1996 and 10% in 2006; whereas, national average state Medicaid spending increased from 12.5% to 14% during that same interval<sup>41</sup>.

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<sup>37</sup> The three urban centers were Oklahoma City, Tulsa, and Lawton.

<sup>38</sup> Verdier JM, Byrd V, Stone C. Enhanced primary care case management programs in Medicaid: Issues and options for states [Internet]. Center for Health Care Strategies. 2009 [accessed 2010 May 17]. Available from: [http://www.chcs.org/usr\\_doc/EPCCM\\_Full\\_Report.pdf](http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf).

<sup>39</sup> Verdier

<sup>40</sup> DeShea L. Return on investment and the health management program in Oklahoma [Internet]. Oklahoma Health Care Authority. [accessed 2010 May 19]. Available from: [http://www.chcs.org/usr\\_doc/Session5\\_OK\\_DeShea\\_ROI.pdf](http://www.chcs.org/usr_doc/Session5_OK_DeShea_ROI.pdf).

<sup>41</sup> Verdier J, Colby M, Lipson D, Simon S, Stone C, Bell T, Byrd V, Lipson M, Perez V. SoonerCare 1115 Waiver evaluation: Final report [Internet]. Mathematica Policy Research. 2009 [accessed 2010 May 18].



Oklahoma was able to achieve lower Medicaid costs per member because of decreased utilization. Between 2004 and 2007, emergency room visits for SoonerCare Choice enrollees decreased from 80 per 1000 months of enrollment to 76 even though national Medicaid ER use rose during that same period. From 2003-2006, adult avoidable hospitalizations decreased 24% in urban and 15% in rural areas<sup>42</sup>.

*Quality:* Reports from Mathematica indicate that quality measures for SoonerCare Choice enrollees have improved. OHCA collects data on 19 quality measures including the percentage of beneficiaries receiving screenings, preventive visits, and on appropriate asthma medications. Through 2007, all measures improved for SoonerCare Choice enrollees. An evaluation of the Health Management Program has been commissioned but has not yet been completed.

## **NORTH CAROLINA**

### **Background and Components**

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In order to increase access and decrease Medicaid spending, Carolina ACCESS began in 1991 as a PCCM program linking Medicaid recipients with medical homes. Participating providers were initially paid a \$3 PMPM case management fee for the first 250 patients and \$2.50 PMPM for each subsequent member<sup>43</sup>. Though promising, Carolina ACCESS was modified in response to increasing budgetary pressures in the 1990s, culminating in the creation of Community Care of North Carolina (CCNC) in 1998. Initially, CCNC was a small pilot program designed to decrease asthma emergency use following the 1997 Balanced Budget Act's mandate that emergency rooms provide services for all emergent medical conditions, but has expanded to cover 900,000 enrollees, or two-thirds of the state's Medicaid population.

PCPs working in counties where CCNC operates are invited to participate, though they must follow clinical practice guidelines, promote patient self-management, and provide 24/7 phone coverage for patients. PCPs unwilling or unable to comply with those requirements are enrolled as ACCESS providers and paid \$1 PMPM. Qualifying CCNC providers join one of the fourteen local networks and paid \$2.50 PMPM. Local networks are paid \$2.50 PMPM to hire case managers, implement population health management programs, provide DM education, coordinate care, and report data back to the state<sup>44</sup>. Relatively high Medicaid reimbursement (95% of Medicare in 2008) in North Carolina has helped CCNC recruitment<sup>45</sup>.

CCNC networks include local PCPs, hospitals, the Department of Social Services, and the local health department. These entities are formally linked, and the resultant non-

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Available from: [http://www.mathematica-mpr.com/publications/redirect\\_PubsDB.asp?strSite=PDFs/soonercarefnlrpt.pdf](http://www.mathematica-mpr.com/publications/redirect_PubsDB.asp?strSite=PDFs/soonercarefnlrpt.pdf).

<sup>42</sup> Verdier

<sup>43</sup> The current per member per month fee is \$1

<sup>44</sup> Ricketts TC, Green S, Silberman P, Howard HA, Poley S. Evaluation of Community Care of North Carolina asthma and diabetes management initiatives: January 2000 – December 2002 [Internet]. The Cecil G. Sheps Center for Health Services Research. 2004 April [accessed 2010 May 19]. Available from: <http://www.communitycarenc.com/PDFDocs/Sheps%20Eval.pdf>.

<sup>45</sup> Verdier

profit corporation uses the case management fees to coordinate services. The Clinical Directors Board is composed of the local network Medical Directors and sets the DM and case management initiatives of CCNC.

## Evaluations

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*Costs and Utilization:* Mercer Government Human Services Consulting prepares annual CCNC savings estimates for North Carolina, based on cost projections in the absence of CCNC:

- 2003: \$60 million
- 2004: \$124 million
- 2005: \$81 million
- 2006: \$162 million
- 2007: \$147 million<sup>46 47 48</sup>

Other analyses have confirmed that the program has produced savings. The Sheps Center estimated that CCNC's asthma initiatives have resulted in \$3.5 million in savings while the diabetes management program has resulted in \$2.1 million in savings when compared to ACCESS patients between 2000-2002. CCNC asthmatics cost \$21 PMPM less than ACCESS enrollees, likely secondary to lower utilization. CCNC asthmatics under 21 had 13% fewer asthma related hospitalizations per 1000 asthmatic enrollees while asthmatics 21 and older had 25% fewer asthma related hospitalizations. Diabetics in CCNC cost \$21 less than ACCESS diabetics in 2002. The hospitalization rate for CCNC diabetics was 9% lower than ACCESS diabetics in 2002<sup>49</sup>. CCNC enrollees without asthma or diabetes also have reduced costs.

*Quality:* A chart review of CCNC enrollees documented a 21% increase in the number of asthmatics that had been staged and a 112% increase in the number of asthmatics with flu vaccines since 2004. Chart reviews also indicated a 7% increase in referrals for dilated eye exams and a 23% increase in foot exams for diabetics between 2000 and 2002<sup>50</sup>.

## INDIANA

### Background and Components

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In 1994, Indiana created separate PCCM and capitated MCO programs. Enrollees receiving Aid to Families with Dependent Children (AFDC) were required to enroll in one of the two programs while ABD enrollment was voluntary. In response to a prior legislative directive, the Indiana Office of Medicaid Policy and Planning (OMPP) developed the Indiana Chronic Disease Management Program (ICDMP) in 2003 to better

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<sup>46</sup> Program Impact. Community Care of North Carolina. Accessed 2010 May 19. Available from: <http://www.communitycarenc.com>

<sup>47</sup> Verdier

<sup>48</sup> Savings estimates do not take into account CCNC expenditures which were estimated to be \$8.1 million in 2002 and \$10.2 million in 2003.

<sup>49</sup> Ricketts

<sup>50</sup> Ricketts

serve ABD patients with diabetes and/or congestive heart failure. ICDMP patients deemed to be at risk for higher future utilization were enrolled into a nurse care management program that provided patient education, encouraged self-management, facilitated communication between providers and patients, and made referrals to community resources<sup>51</sup>. Low risk patients were offered a less intensive telephone-based care management program. In the same year, OMPP enrolled ABD beneficiaries into an enhanced PCCM program called Medicaid Select, which was administered by AmeriChoice and provided client and provider services and a free member services hotline.

In 2008, following the election of a new governor, OMPP reviewed the state's Medicaid managed care programs and decided to replace ICDMP and Medicaid Select with Care Select. Enrollment into Care Select is mandatory for the ABD population. Like ICDMP, Care Select divides patients into risk categories so that low risk enrollees receive telephone contact and high-risk enrollees benefit from in-person contact from care coordinators. PCPs are responsible for providing and coordinating care with the assistance of two care management organizations (CMOs) – ADVANTAGE Health Solutions and MDwise. In exchange for a \$25 PMPM care management fee, CMOs are responsible for developing individual care plans for enrollees. 20% of the care management fee is withheld and contingent on the performance of CMOs on quality measures such as avoidable hospitalizations, emergency room utilization, and breast cancer screening. Physicians are paid \$15 PMPM for care coordination and management activities and receive \$40 per patient for care coordination conferences with CMOs (up to two per year per patient), helping to offset the relatively low Medicaid reimbursement rates in Indiana (69% of Medicare in 2008)<sup>52</sup>.

## **Evaluations**

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*Costs and Utilization:* Indiana University evaluated the costs associated with ICDMP and found that compared to baseline figures, the rate of growth of total claims decreased after program implementation<sup>53</sup>. In a randomized controlled trial comparing ICDMP enrollees to control practice populations, researchers found that the average monthly claim paid for CHF members was \$283.01 lower in the ICDMP group<sup>54</sup> although that difference did not translate to diabetic patients. Burns & Associates, an Arizona health policy consulting firm, will perform the evaluation of the Care Select program.

Data on the impact of these programs on quality measures are not currently publicly available.

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<sup>51</sup> Rosenman MB, Homes AN, Ackermann RT, Murray MD, Doebbeling C, Katz B, Li J, Zillich A, Prescott VM, Downs SM, Inui TS. The Indiana Chronic Disease Management Program. *Milbank Q.* 2006; 84(1): 135-163.

<sup>52</sup> Verdier

<sup>53</sup> Katz BP, Homes AN, Stump TE, Downs SM, Zillich AJ, Ackermann RT, Inui TS. The Indiana Chronic Disease Management Program's impact on Medicaid claims. *Medical Care.* 2009; 47(2): 154-160.

<sup>54</sup> Holmes AM, Ackerman RD, Zillich AJ, Katz BP, Downs SM, Inui TS. The net fiscal impact of a chronic disease management program: Indiana Medicaid. *Health Aff (Millwood).* 2008; 27(3): 855-864.