HFMA Gulf Coast

Building a Statewide Clinically Integrated Delivery System

May 9, 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 nationally.
- Introduce an innovative, statewide approach to developing a clinically integrated delivery system.
- Review the key components of the model (clinical, financial, information technology [IT], provider 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 are collaborating 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

This movement to value-based care entails a shift from the previously fragmented healthcare system to a focus on the patient’s total healthcare picture across the full continuum.
I. Setting the Stage
Drivers of Change in the Market

MACRA (MIPS/APM), CPC+, CJR, Medicaid ACO

FFS to FFV, BCBS
PCMH, Cigna
ACOs, Managed
Care Organizations (MCOs)

CINs, ACOs,
Alliances, Joint
Ventures, Mergers
and Acquisitions

Increasing cost
transparency, shopping around, engagement in health

Regulators

Payors

Collaborations
and Partnerships

Consumers

As a result of the current healthcare landscape, providers are experiencing four major forces that are pushing them to deliver higher-quality care at a lower cost.
Managed care has become the predominant method for delivering healthcare in the Medicaid program over the last decade, with higher rates of adoption since the passage of the ACA in order to finance care delivery to an expanded Medicaid population nationally.

By 2013, seven states had over 90% of their Medicaid populations enrolled in MCOs.

Since then, six more states have moved to enroll over 90% of their population in managed care.
I. Setting the Stage
Illinois Medicaid Reform Law

Illinois is following the national trend by moving the Illinois Medicaid program from a fundamentally 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 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.
I. Setting the Stage
Illinois Medicaid Reform Law (continued)

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, which included 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.
Illinois HFS developed two contract phases to allow for the development of care coordination, health plan capabilities, and experience in monitoring quality and performance. The long-term vision involved taking full risk, developing into an MCO, and further integrating clinical data across the network.

### Population Health Maturity

<table>
<thead>
<tr>
<th>Organizational Foundation</th>
<th>Provider Network</th>
<th>Payment Models</th>
<th>Care Models</th>
<th>Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Highly Evolved</strong> (PHM 301)</td>
<td>Formal and active PHM structure with specific (FTE) PHM leadership</td>
<td>Fully contracted network, direct to employer</td>
<td>Capitation, payor collaboration</td>
<td>Coordination across all patient populations</td>
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<tr>
<td><strong>Transitional</strong> (PHM 201)</td>
<td>Organization engaged in opportunities in PHM and willing to make investments</td>
<td>Inclusion of specialists and contractors; performance requirements</td>
<td>Upside/downside risk bundles</td>
<td>Coordination across larger patient populations</td>
</tr>
<tr>
<td><strong>Developing</strong> (PHM 101)</td>
<td>Existing but not prolific PHM structure</td>
<td>Open network, PCP-driven</td>
<td>P4P, upside-only shared savings, PMPM</td>
<td>Coordination across certain conditions or service lines</td>
</tr>
<tr>
<td><strong>No Development</strong></td>
<td>No quality committees, no defined business strategies for PHM</td>
<td>No provider alignment</td>
<td>FFS</td>
<td>No integration or care coordination</td>
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I. **Setting the Stage**

**Mandatory Phasing**

- **Goal at Month 18**
  - Developing (PHM 101)
  - No Development

- **Goal at Month 36**
  - Highly Evolved (PHM 301)
  - Transitional (PHM 201)
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.

- **Phase I**
  - High: Fully Integrated Operations
  - Medium: Single Care Model
  - Low: Shared Protocols, Centralized Services

- **Phase II**
  - High: Common Targets, Uniform Metrics
  - Medium: Common Clinical Focus, Shared Clinical Vision
  - Low: Independent Visions

The IPH care model allows for regional variation in execution but develops a central framework with consistent core competencies and measures across the IPH.
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.

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

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

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

» 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.
II. IPH Formation
Provider Network

Critical to the success of the IPH was the maintenance of an attractive provider network that ensured adequacy and demonstrated capacity to serve the 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.
Initially, the IPH did not assume full financial risk and did not manage claims. After Month 18, IPH was prepared to take full risk and manage the population under a health plan structure similar to an MCO.
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.
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.
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 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
IV. Lessons Learned

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**

ECG partners with providers to create the strategies and solutions that are transforming healthcare delivery. With more than 40 years of service to the healthcare industry, we can help your organization thrive in a value-based world.