Margaret Kirkegaard, MD, MPH, Medical Director, Illinois Health Connect
Illinois Primary Care Case Management Program
Testimony for the Illinois House and Senate Special Committees on Medicaid Reform
December 11, 2010

I. Description of Illinois Health Connect

In 2006, the Illinois Department of Healthcare and Family Services (HFS) implemented a Primary Care Case Management Program founded on the Medical Home concept. The program is called Illinois Health Connect and it is administered by Automated Health Systems. While there are varying definitions of the "Medical Home", all definitions agree that the concept refers to a primary health care team delivering accessible, continuous, compassionate, coordinated and culturally competent care. After four years, there more than 5,700 participating medical homes which include primary care physicians, federally qualified health centers, rural health centers, nurse practitioners, and other qualified providers. Participating medical homes agree to adhere to quality standards such as 24/7 coverage and office hours.

Approximately 2.0 million of total 2.6 million IDHFS clients are mandatorily eligible to choose a medical home. Clients in some counties can choose a medical home through a managed care organization (MCO) .The total number of clients selecting MCO is 200,000. The remaining 1.8 million clients are enrolled in Illinois Health Connect but the overall capacity of the IHC network is 5.4 million.

Illinois Health Connect was recently named 2010 Provider of the Year by the Campaign for Better Health Care for ensuring that 1.8 million clients have a medical home and for "bringing Illinois Medicaid into the 21st century."

a. IHC Enrollee Services

The Illinois Health Connect call center receives up to 80,000 calls per month and assists clients in enrolling in the "best fit" medical home. A mother can call and ask for a pediatrician who speaks Polish and is on the bus route and IHC can assist her in getting connected to that medical home. Over the past four years, Illinois Health Connect has worked hard to educate patients about the concept of the medical home and the importance of continuity of care. In a recent survey of randomly selected Illinois families conducted by the University of Illinois at Chicago (UIC), respondents with children insured through HFS were significantly more likely to report their children had a "medical home" than were caregivers of children enrolled in private health insurance plans and uninsured children. Fewer respondents with children enrolled in All Kids were unclear about the meaning of "medical home" compared to respondents with privately insured children. (For additional information please see: http://www.hfs.illinois.gov/assets/072010_akfinal.pdf)

IHC call center staff also work to educate families about the importance of well-child care as the cornerstone of pediatric health care. All families who contact the call center for any reason

receive counseling on whether the children in that household are up-to-date on their well-child care. The UIC study also found that HFS enrolled clients had equal access to well child services through their medical home as privately insured children.

Additionally, IHC contacts each adult client annually through a phone call or letter encouraging them to make an appointment for an annual check-up. IHC also assists clients with accessing specialty care and community services such as services through Early Intervention or Department of Mental Health.

b. IHC Provider Services

Illinois Health Connect has created a robust network while at the same time allowing providers high control over their participation. When a provider enrolls with IHC as a medical home, the provider indicates the maximum number of patients that the medical home can care for and other parameters that would determine which patients would be best suited to that medical home such as the age of the patient. Physicians value this high degree of control and it has contributed to the successful development of the IHC PCP network. IHC currently has 5,700 medical homes enrolled with a capacity for 5.4 million clients, three times the current client enrollment.

Enrolled providers receive support through a variety of mechanisms. IHC operates a Provider Services Helpdesk that is open Monday through Friday from 8:00 am to 7:00 pm. IHC also keeps providers up to date through blast faxes and emails, quarterly newsletters, website postings and webinars. IHC Provider Service Representatives make 350 visits to provider offices per week providing academic detailing on subjects such as enrollment, billing and coding, and participation requirements. There are five advisory subcommittees that meet 2 to 4 times per year with open participation that creates nearly 20 opportunities to provide input from the front lines of clinical care. This communication infrastructure also serves to give participating providers a voice in policy development.

c. Quality Assurance Tools

Through advanced technological infrastructure, IHC is able to provide a number of quality tools to the medical home. IHC creates a Panel Roster for every PCP that is available online and updated daily. The Panel Roster shows clinical information such as which patients are due for mammography or lead screening. In this way, IHC supports the quality improvement efforts of the medical home. Another quality tool is the Provider Profile that is sent to every provider semi-annually providing feedback on clinical metrics such as immunization rates.
IHC also employs a team of Quality Assurance Nurses who meet with providers in their offices to discuss clinical outcomes on the quality tools and potential quality improvement strategies. Illinois Health Connect has created a Bonus Payment Program for High Performance that allows providers to be compensated for achieving certain benchmarks on nationally established primary care measures such as rates of mammography and pediatric developmental screening. In 2009, $2.8 million dollars were dispersed to IHC PCPs; and in 2010, $3.2 million dollars were dispersed. Some providers received bonuses up to $40, 000.

II. Illinois Health Connect Outcomes

a. Client Satisfaction

Illinois Health Connect has performed an annual client satisfaction survey in 2009 and 2010. In the 2010 survey, 99% of urban respondents and 91% of rural respondents indicated that they knew their medical home. In both years and for both rural and urban clients, at least 97% of respondents were satisfied or highly satisfied with their medical home and 95% were satisfied or highly satisfied with the administration of Illinois Health Connect.

b. Provider Satisfaction

Illinois Health Connect also performs an annual provider satisfaction survey. In the most recent survey, a total of 1,136 surveys were returned. Over 92% of respondents agreed or strongly agreed that Illinois Health Connect is beneficial to patients and nearly 85% of respondents were satisfied with the administration of the IHC program.
(For additional results, please see:
http://www.illinoishealthconnect.com/files/ProviderImportantNotices/Survey_2010_Summary_final_8_20_2010.pdf)

c. Clinical Outcomes

Throughout the past four years, Illinois Health Connect has tracked standard, population-based health outcomes. Most have shown a modest improvement. A few examples are: The rate of developmental screening to identify kids who are at risk for life-long disabilities has increased over 10%. Rates of adolescent check-ups have increased nearly 4%. Healthier kids and families mean better school performance, a more productive workforce and healthier communities. IHC has been able to improve clinical outcomes while controlling costs.

d. Financial Outcomes

Analysis indicates that Illinois Health Connect has achieved a reduction in both Emergency Department (ED) utilization and hospitalizations. This is a central tenet of the medical home model, that if care can be coordinated and provided through the medical home, fewer patients will get out of control and require expensive hospitalizations and emergency care. If patients have a medical home and understand the medical home concept, they will be less likely to use the ED unnecessarily. Cost savings attributed to IHC were estimated at $80 million in FY 2008 and $120 million in FY 2009.

III. Proposed Reforms

a. Mandatory Managed Care

During the debate on controlling health care costs for Medicaid, many have proposed mandatory managed care as a solution. While there are various models of managed care, most rely on utilization review or utilization management as a means of controlling costs. Many

physicians and patients regard this as an unnecessary intrusion into the doctor-patient relationship. The history of Medicaid managed care in Illinois has been marred by aggressive marketing practices that defrauded patients. A 1998 Chicago Reporter Article outlines the various abuses which were enumerated in a study performed by the Chicago Department of Public Health. (For additional information, please see: http://www.chicagoreporter.com/index.php/c/Inside_Stories/d/Troubled_Times_for_Chicago%E2%80%99s_Medicaid_HMOs)

Currently, 1,279,100 clients live in a county with eligibility to voluntarily select a Medicaid managed care plan. All clients receive three mailings describing their choices and, if they contact the Illinois Client Enrollment Broker, they will receive additional counseling over the phone about their various choices. Only 15% of eligible clients or 194,521 clients have selected a managed care plan at this time. This indicates that even when educated on the potential benefits of the available Medicaid managed care options, most clients do not select this option.

b. Strengthen Primary Care and Medical Home Infrastructure

The single most important strategy in reducing costs and improving health outcomes for Illinois Medicaid clients is strengthening the overall primary care infrastructure and specifically enhancing the medical home model. There is a substantial body of research that demonstrates that health care systems with strong primary care experience lower costs and improved outcomes. One of the premier primary care researchers in the world, Barbara Starfield, summarized the research about primary care and the medical home model:

"International and with-in nation studies indicate that a relationship with a medical home is associated with better health, on both the individual and population levels, with lower overall costs of care and with reduction of disparities in health..."
(Starfield and Shi, *Pediatrics* 2004;113:1493-1498)

The medical home model also offers the additional benefit of being able to reduce health disparities, which is a significant problem for the Chicago population. In order to strengthen the medical home model for Illinois Medicaid clients, the following four strategies should be considered:

i. Accelerate the adoption of medical home attributes.

While there are various definitions of the "medical home", the American Academy of Pediatrics describes it as "a community-based primary care setting that integrates quality and evidence-based standards in providing and coordinating family-centered health promotion in wellness, acute and chronic condition management." Several national organizations have developed standards to assess the degree or level of "medical homeness" of a primary care practice. Two of these are: National Committee on Quality Assurance (NCQA; http://www.ncqa.org/tabid/631/Default.aspx) and URAC (http://www.urac.org/press/cmsDocument.aspx?id=724)

The most efficient way to accelerate the adoption of medical home attributes is to stratify the care management fees available to each medical home. For example, a

research study found that patients who were linked to a primary care practice that had at least 12 hours of appointment time available afterhours used the emergency department 20% less than patients who did not have access to a medical home with expanded access. (Lowe RA *et al, Medical Care* 2005;43:792-800) By engineering the medical home, the State of Illinois can avoid expensive ED utilization.

Another strategy that has been recommended by health policy researchers for accelerating the development of the medical home is to implement an outreach model of academic detailing modeled on the successful agricultural extension model. The 2010 Patient Protection and Affordability Care Act contains provisions for pilot testing extension models in primary care. This could build on the highly popular and successful academic detailing already performed for providers through the Illinois Health Connect infrastructure.

ii. Integrate Behavioral Health Care into the Medical Home

Medicaid patients are more likely to have behavioral health co-morbidities leading to poor health literacy, poor adherence to medical recommendations, higher utilization of services and higher utilization of inappropriate services. Co-location of behavioral health providers within the medical home can reduce the stigma of accessing behavioral health services. Modification of the state confidentiality statutes on behavioral health services will also serve to strengthen linkages between the medical home and behavioral health services.

iii. Strengthen Care Coordination

Care coordination is critical to a high functioning medical home and the ability to both reduce costs and improve outcomes. There are three possible options for strengthening care coordination. The first is to the expansion and enhancement of care coordination services through the Illinois Health Connect infrastructure. For example, IHC has developed a Provider Portal where providers can access their quality tools. The Provider Portal houses a database of most claims for the past two years for every current Medicaid client. This database already allows providers to determine what services, prescriptions and diagnostic testing have been rendered to clients for the past two years. The Portal could be enhanced with reports such as weekly listings of patient who have been hospitalized in order to ensure that patients receive e timely follow up and do not require readmission. The primary care case management program in Pennsylvania expanded the phone counseling offered to clients through the enrollment call center to target unnecessary ED utilization. This counseling combined with outreach to both medical homes and EDs was highly successful. From 2006 to 2008, the decrease in Emergency Department visits per 1000 member months among the total PCCM population decreased from 61.08 to 39.85, a 34.8% decrease. (personal communication with PA AccessPlus program manager)

Another potential model for care coordination is to develop services through an outside agency that works collaboratively with the medical home. The very successful Your Healthcare Plus (YHP) program which currently provides disease management and care coordination services to 280,000 of the sickest and highest utilizing patients in the

Illinois Health Connect program is an example of this type of external care coordination. YHP has saved an additional $307 million dollars over the life of the program.

Other states such as North Carolina have adopted a model of shared care coordination resources through local communities based agencies. This model has been successful but also required sufficient time to develop organic relationships with multiple providers and local care coordination services.

iv. Engage in Multi-payer Dialogue

One of the most significant barriers to the transformation of primary care to highly functioning medical homes is the overall disorganization of the healthcare delivery system and the existence of multiple payers each with their own incentives. Healthcare delivery requires the coordination of the whole team. A practice cannot align all of their internal resources when there are competing quality improvement priorities. Illinois should foster an environment where public and private payers are aligned so that practices can efficiently allocate resources.

c. Pilot use of E-consultation to improve access to specialty care

Physicians have always relied on informal consultation as way of borrowing the expertise of other practitioners. This is commonly referred to as "sidewalk" consultation. In order to expand access to specialty care, Illinois should create a formal structure for electronic consultations where the medical home can receive appropriate medical guidance on the management of certain medical conditions. Specialty providers could be paid for these services but would not have to allocate internal office resources to patient appointments. This would also eliminate the possibility of missed appointments, the need for interpreter services at the specialty care office and the transportation services to the specialty office. Certain specialties are particularly amenable to such consultation such as dermatology, hepatology and endocrinology. The medical home would be required to transmit standard information via the secure IHC Provider Portal and the specialist would review the information and communicate recommendations back to the medical home. While this would not eliminate the need for all specialty consultations, many preliminary consultations could be accomplished through this mechanism making the subsequent specialty visits more efficient. This type of e-consultation has been used very successfully in the uninsured population of San Francisco.

d. Development of Accountable Care Organizations

Illinois should pursue models of healthcare integration such as the Accountable Care Organizations (ACO). However, a strong accountable care organization requires a strong medical home network as the base. While great strides have been achieved in the development of the medical home infrastructure through the Illinois Health Connect program, the healthcare delivery landscape in Illinois is still relatively disorganized and fragmented. An article published in the December 10th, 2009 edition of New England Journal of Medicine described the relationship between the Patient-Centered Medical Home and Accountable Care Organizations as:

"These two approaches are synergistic models of delivery-system reform that, together, promise to redirect the U.S. delivery system toward reduced cost growth and improved quality. ACOs will require a strong primary care core to succeed and, in turn, can provide essential delivery-system infrastructure beyond the primary care practice to ensure the full realization of the PCMH model."

Any pilot program for ACO development should be based on a strong medical home foundation. Additionally, because the ACO model is relatively untested, targeted pilots should be completed prior to expansion. For example, since the Illinois Department of Healthcare and Family Services insures 52% of births in Illinois, maternity care represents a unique opportunity to develop the ACO model. Maternity care represents one single "disease condition" (i.e pregnancy) with a spectrum of well-defined and measurable outcomes such as prematurity, birth weight and rate of C-sections. A system of regional perinatal networks already exists to provide some cohesion of the various perinatal services.

In summary, Illinois Health Connect represents a successful implementation of the medical home model on a broad scale and ensures a medical home for 1.8 million patients while improving outcomes and controlling costs. Further Medicaid reforms in Illinois should build on this successful program and the medical home model. *Every patient deserves a medical home.*