ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Bruce Rauner, Governor
Felicia F. Norwood, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

September 25, 2015

Julie Sharp, M.P.P.
Technical Director
Division of State Demonstrations and Waivers
State Demonstrations Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

Dear Ms. Sharp:

The State of Illinois and the Cook County Health and Hospital System wish to thank you for your ongoing support of the Illinois Cook CountyCare (Project # 11-W-00281/5) 1115 Demonstration waiver. Through collaboration with federal, state and county agencies the project resulted in creating the opportunity for many Illinoisans to access health care.

This letter is accompanied by the following document:

1) CountyCare Waiver Final Report

We understand that the cost reconciliation portion of the waiver Special Terms and Conditions is now the only remaining item prior to closing out the demonstration. As we have communicated to you via email, we are making progress toward completing this task with the expectation of meeting the November 30, 2015 deadline.

Sincerely,

[redacted]

Teresa Hursey
Acting Medicaid Administrator
Division of Medical Programs
Illinois Department of Healthcare and Family Services

Illinois/Cook County Care Section 1115 Waiver Final Report

Demonstration Years: **1 and 2** (Date of approval letter through June 30, 2014)
Federal Fiscal Years: **2013 and 2014**

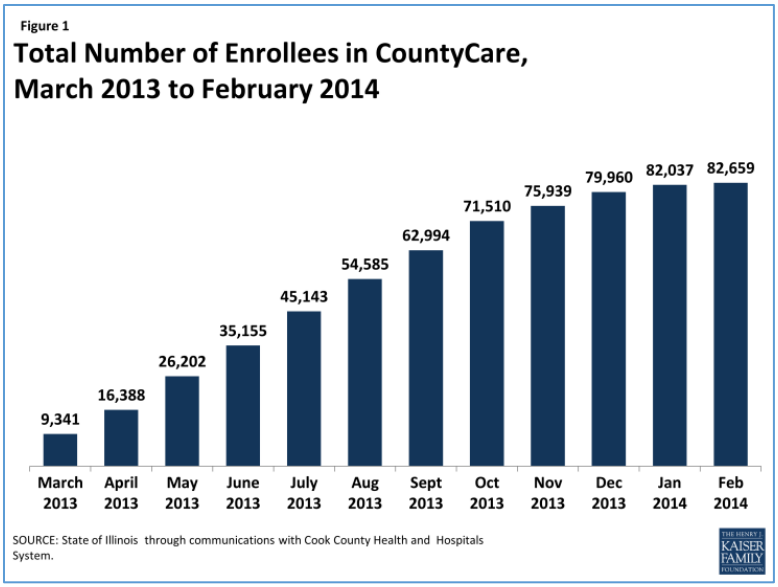
I. Introduction

The State of Illinois 1115 Medicaid early expansion waiver submitted on behalf of the Cook County Health and Hospitals System (CCHHS) was approved on October 26, 2012. CCHHS operated the program as CountyCare. This final report of the waiver demonstration serves to summarize accomplishments, issues and lessons learned from the initiation of the waiver. The report is organized in a similar fashion as quarterly reports submitted over the course of the demonstration waiver with the following components of the waiver addressed sequentially: Enrollment Information, Benefits Information, Assignment of a Primary Care Medical Home, Community Partners, Outreach/Innovative Activities, Operational and Policy Development Issues, Expenditure Containment Initiatives, Budget Neutrality, Consumer Issues, Quality Assurance/Monitoring, Demonstration Evaluation, and Transition Plan.

Upon waiver end, CountyCare became a state approved Medicaid managed care organization known as a Managed Care Community Network (MCCN). As an MCCN, CountyCare, in addition to continuing to serve the ACA adult expansion population, serves Medicaid enrollees eligible for Family Health Plans coverage as a pregnant woman, parent or caretaker relative or child or the Integrated Care Plan for seniors and persons with disabilities who do not have Medicare coverage.

II. Enrollment & Membership

CountyCare had a consistent enrollment increase over the course of the waiver period with a cumulative 116,500 individuals enrolled over the 18 month period. The success of our enrollment efforts were highlighted by the Kaiser Family Foundation (KFF) in its *Profiles of Medicaid Outreach and Enrollment Strategies: The Cook County Early Expansion Initiative* published April 7, 2014. The chart below, as presented by KFF, illustrates this success.



On April 1, 2013 the CountyCare Third Party Administrator (TPA) engaged the advocacy organization, Treatment Alternatives for Safe Communities (TASC), to be application assisters in Cook County jail. TASC advocates for people in courts, jails, prison, and child welfare systems who need treatment for alcohol/drug and mental health problems. This new process placed the TASC App Assistor as part of the detainee intake process conducted by the Sheriff. As the table below shows, TASC initiated nearly 16,000 applications, submitting over 7,000 for processing with an approval rate of 78% (5,589).This landmark initiative illustrates the power of the ACA on communities and populations historically outside the health care market.

Table 1: CountyCare Applications @ Cook County Jail

Month/Yr	Applications Initiated	Applications Submitted	Applications Approved	Applications Denied
Apr'14	1,504	6	0	0
May'14	1,315	43	0	2
Jun'14	1,038	478	9	5
Jul'14	897	775	43	12
Aug'14	1,002	536	311	49
Sept'14	908	375	552	107
Oct'14	1,639	404	433	104
Nov'14	1,592	192	225	82
Dec'14	1,332	310	403	86
Jan'15	1,308	913	348	72
Feb'15	989	658	306	40
Mar'15	584	685	717	31
Apr'15	380	416	827	62
May'15	551	585	455	222
Jun'15	769	759	960	78
TOTAL	**15,808**	**7,135**	**5,589**	**952**
		45%	**78%**	**13%**

As expected, Table 2 shows that the age distribution of CountyCare members is skewed towards those over age 50. However, it was surprising to see that one-third of members were younger, between 19 and 24 years old.

Table 2: CountyCare Member by Age Group as of 6/30/2014

Age Group	# Members	% Members
19-24 Years Old	32,888	33.4%
35-49 Years Old	24,111	24.5%
50-64 Years Old	41,474	42.1%

The high number of applications processed and submitted to the IL Department of Human Services (DHS) overwhelmed the assigned office's ability to complete processing in a timely manner. At the peak of application submission, we experienced up to a 160-day delay in processing from date of submission to decision.

In retrospect, a lack of presumptive eligibility caused the lengthy delays in application processing and getting people enrolled into coverage. This delay in enrollment also meant a delay in access to benefits, as several providers – especially pharmacies – would not provide service while an individual's application was in a 'pending' status.

On a daily basis, DHS provided CountyCare with the unofficial approval and denials for the day, along with denial codes. This data was entered into the CCHHS enrollment system and it generated an email to the application assister that submitted the application. This enabled us to follow-up with the applicant to address the reason for denial.

III. Benefits Information

Care management needs evolved as the CountyCare population grew. Over the course of the demonstration project, CountyCare more clearly defined sub-populations and a structured approach to leverage network resources. For example, we arranged for the population with Hemophilia to be cared for by a Regional Hemophilia Center, we designated the CCHHS Core Center as the medical home for persons with HIV/AIDS, CCHHS -- a leader in Hepatitis care – provided comprehensive service to persons with Hepatitis C. CountyCare developed guidelines for the approval of new antiretroviral medications for Hepatitis C so that the new high-cost treatments would be available to members who met medical necessity guidelines.

CountyCare moved toward a model of greater integration of behavioral health and physical health care, offering behavioral health services to members during their post discharge follow up call and active integration through jointly sponsored case review. These joint case reviews occurred weekly between CountyCare's medical management team, and clinicians at PsycHealth, CountyCare's contracted behavioral health benefits manager. Individuals with mental health and substance use problems who were brought into care under the waiver were

given priority to engage them in care.

Public transportation, the transportation benefit enacted by CountyCare, has proven to not be sufficient for some fragile CountyCare members, particularly for those needing to come in for a follow-up PCP visit after a hospital discharge. CountyCare secured additional Medicare transportation as a covered service for members with conditions that make it difficult/impossible to navigate the use of public transportation.

Some patients required physical therapy, speech therapy and occupational therapy in greater intensity than what was allotted under the waiver's approved benefits package. As a result, CountyCare expanded the number of visits allowed from 20 to 45. Similarly, homecare was insufficient for some members and the benefit was increased from 25 visits to 45 home visits. Access to respite housing was added as a benefit to ensure that homeless individuals have a place to go to recuperate after a hospital stay and to appropriately free up acute care beds for those who require this level of service.

In January 2014, HFS added audiology and vision benefits for Medicaid beneficiaries.

IV. Assignment of a Primary Care Medical Home

Table 3 highlights the total number of enrollees in CountyCare, and those that have chosen a PCP site. Provider assignment was completed at time of application, not at approval. As a result, the assigned number of CountyCare members is higher than would be anticipated for a pilot of this scale.

Table 3. Enrollees and Empanelment, June 2014

Demonstration Population	Enrollees	Enrollees with PCP Choice
County Care	**93,567**	**96,322 (99.7%)**

V. Updates on Additional Community Partners

An aggressive plan of outreach to prospective partners was carried out during the course of the waiver demonstration. We continually identified service and geographic gaps in the network and targeted those that would make a truly comprehensive network with exceptional geographic coverage in regions of the County where clusters of CountyCare enrollees reside. While the nature of the network is dynamic and will continue to evolve, CountyCare had tremendous success in establishing a network scalable to serve its new membership. Built on the 'backs' of the Federally Qualified Health Centers (FQHCs), the CountyCare network developed during the waiver included:

- Every FQHC operating in Cook County (26 organizations, 180+ access points),
- The American Indian Health Service,

- All six major academic medical centers in Cook County,
- 35 community hospitals, and
- Hundreds of other ancillary providers.

The majority of network provider contracts are set at standard Medicaid rates, with some ranging to 110% or 140% of Medicaid. These payments in excess of standard Medicaid rates are due to several factors, including:

- Payment of add-on fees for certain Disproportionate Share (DSH) facilities,
- Supply and demand on selected services, such as home health where the traditional reimbursement does not cover the cost for the agency to do their work, and
- Specific-specialty care, such as orthopedics, where there is limited participation in the Medicaid program.

Among the greatest network challenges faced by CountyCare was contracting with rehabilitative therapies and home health care. Homecare enables patients to be discharged from the hospital to complete their therapy at home which is a critical cost-savings measure. Yet, the IL Medicaid reimbursement rate is unsustainable to many providers. As a result, CountyCare increased the contract rate to be able to provide this service.

Similarly, reimbursement for home-based physical, speech and occupational therapy is reported to be less than half of what it costs vendors to provide the service. Many of the post-hospitalized patients often lack the stamina to travel, and this therapy is necessary to support their continued recovery. To launch the CountyCare network, single member case agreements at a rate that enables CountyCare to secure the service were secured. This is not scalable and will have significant financial challenges as the patient volume increases. Ultimately, CountyCare was able to increase network capacity for these services and has been able to reimburse providers at more standard Medicaid rates.

Overall the CountyCare reception from the provider community has been positive and our ability to establish a provider network paying standard Medicaid rates was successful the majority of the time. Providers that participated in traditional Medicaid programs have been, for the most part, willing to join. We learned that a factor that drives some of this success is the fact that CountyCare members were historically self-pay patients with little to no income provided for the care provided to them. The early ACA enrollment changed that, making providers eager to sign on.

VI. Outreach/Innovative Activities

CountyCare has established a variety of successful, community-based enrollment and outreach strategies that helped lead to high enrollment numbers. Key components of the outreach strategy are described below.

- Trained more than 500 application assistors to help individuals apply for CountyCare by

phone and in person. Application assistors are employees of contracted CCHHS vendors, CountyCare network primary care providers, and a contracted social service agency with experience working with criminal justice involved individuals. CountyCare hired individuals with previous Medicaid experience and required all assistors to attend CountyCare application assistance training provided either by CountyCare staff by webinar or in-person training provided by their organization's application assistance lead.

- Established multiple methods and locations for individuals to apply for the program.
- Engaged in frequent communication with state eligibility staff to assure that CountyCare established application assistance policy and procedures consistent with state eligibility staff procedures. Submitted complete CountyCare applications to state eligibility staff to minimize the amount of follow-up required by state eligibility staff. Continually simplified and streamlined application requirements and documentation requirements for citizenship verification.
- Conducted targeted outreach calls to CCHHS patients that were identified as being potentially eligible for the waiver. The CountyCare Call Center made outreach calls to such patients. Each clinic selected a well-known provider, nurse, or clerk to record the message. When called, the patient was encouraged to apply via phone either by pressing 1 and applying or calling back. Additionally, FQHCs were encouraged to use this service and many did. CountyCare also called those that lost General Assistance during the waiver period.
- Initiated application assistance with Cook County jail detainees who are screened as likely eligible; the initiative is believed to have national significance, and is one that CountyCare and CCHHS are actively evaluating.
- Hired two complementary outreach vendors to implement community-based outreach strategies – one with strength in the faith-based community, and one with deep roots in the various Hispanic communities across the County. In addition, staff from CCHHS worked on CountyCare and CCHHS promotion. In total CountyCare averaged ten events per week, reaching up to 10,000 individuals per week with outreach contacts to promote CountyCare, explain the program, encourage individuals to apply for the program and to hand out CountyCare materials (which had been translated into multiple languages.) These events were held in collaboration with a large number of community partners and in a myriad of community settings. These vendors partnered with organizations to host enrollment events at health centers and other community locations, and took contact information of interested potential members for follow up by our call center which yielded a 15% return.
- Engaged an additional vendor to develop a media strategy. The vendor not only developed a media strategy for CountyCare but also designed strategic creative materials for the program. Materials developed included flyers, posters, brochures and banners. Hundreds of thousands of these materials have been produced and over 500,000 pieces have been used throughout Cook County. A media buy was completed

which allowed thousands of posters to be placed at small neighborhood billboards strategically placed based on a demographic analysis of where the potential population travel or live.

A multi-faceted media and outreach strategy with multiple methods and locations for individuals to apply for the program was key to achieving a large volume of applications. Training application assistors already familiar with the complexities of Medicaid eligibility rules was critical to a quick start up since application assistors without Medicaid experience often require more training.

VII. Operational/Policy Development

A multitude of operational and policy issues were identified, most of which were successfully addressed during the course of the demonstration. To enroll such a large volume, efficiency in the application and enrollment process was paramount. There were significant and successful efforts made to reduce cycle time between application initiative and submission to the state. In addition, HFS allowed CountyCare to visit its CountyCare processing facility with its contracted Six Sigma Black Belt vendor to identify efficiency opportunities to assist the State in their processing approach.

There were several accomplishments in building the infrastructure for CountyCare operations, including the recruitment of highly qualified staff for key positions and the strategic creation of new positions. These included the hiring of a permanent Executive Director, Medical Director, and Utilization Management Nurse. It also involved the creation of new positions including the Manager of Provider Relations, and a Clinical Operations Director.

Table 4 identifies selected significant operational and policy issues identified over the course of the demonstration project and how they were addressed.

Table 4: Issues and Updates Related to Waiver Operations and Policy, June 30 2014

Issue	Updates as of the End of the Demonstration
Improving the hiring timeframe within CCHHS to staff the Patient Centered Medical Home (PCMH) model across the system. The PCMH teams are not fully functional in all sites.	PCMH sites within CCHHS continue to fill positions. As more hiring processes transition in- house, we expect this to continue to improve.
Although every applicant was asked to choose a PCMH site at the time of application, many were hesitant to do so. Applicants want more time to think about the options presented before deciding. Once an application is submitted to DHS, if an applicant has not made a selection, as of June 3, 2014, they were auto-assigned.	We have made significant strides in assigning members to a PCMH site with 99.7% of members selecting their chosen site.

Issue	Updates as of the End of the Demonstration
The quick start-up and prolonged procurement process within Cook County led to some delays by the TPA configuring their system and loading in the provider contracted rates. It took until May 2013 before claims started to be paid. Currently, claims are being paid. CountyCare engaged a claims auditor to review the majority of claims to identify system loading issues.	The TPA claims configuration system is set in place and is paying claims. CCHHS provided TPA with additional pricing information that TPA could not acquire. In addition, it was requested the PPS rates for FQHCs be cross-walked against 2014. Request for Aged Claims Report submitted. During quarters 1 and 2 of 2014, all rates were reviewed and adjusted accordingly to ensure proper payment.
CountyCare changed the point in the process where a 10-question health screen occurs, to time of application, not enrollment. This allows the TPA to send the results of the screen when a panel roster is available to each PCMH site. Not only are new members listed on the panel roster but —pending applicants are also listed, with the results of the health screen. Since CCHHS and FQHCs provide service —regardless of one's ability to pay, they reach out to higher risk applicants to begin the care management process.	The results of the Health Needs Assessment (HNA) illustrate significant limits on access to services and the instability of CountyCare members. Highlights of the HNA data are: 59% of applicants do not have a medical home 85% of applicants are not able to obtain medications when prescribed 76% of applicants were hospitalized or in an ED within six months of applying for CountyCare 19% of applicants report being worried about having a place to sleep tonight or in the near future

The application to the state for CountyCare to transition to a County Managed Care Community Network (MCCN) – a Medicaid managed care entity recognized by the State of IL -- brought several new issues to the table that needed to be addressed. These were related to, for example, the process of transitioning to the new eligibility system, covered services, notices to current CountyCare members, the future PMPM rate, etc. CCHSS held monthly meetings with key network providers to assist with this transition. All issues were resolved and the County MCCN contract was executed for a July 1, 2014 start date.

VIII. Expenditure Containment Initiatives

A key issue that was addressed during the course of the demonstration was the fact that membership eligibility started the first day of the month the application was submitted, not the subsequent month after processing. This was extremely problematic as DHS had a protracted processing time. Operationally, that meant that applicants (whose applications were pending) were accessing care after their applications were submitted to DHS but before CountyCare was notified of HFS approval.

For example, Table 5 displays the retroactive PMPM coverage – based on date of application approval -- for the June 2014 monthly audit file. Of the 7,455 new members in June, the

majority had benefit coverage within 60 days of the application date. This is a significant improvement over the quarter ending March 2014 where, of the 6,456 new members, the majority (6,083) had their coverage begin retroactively to their application month, some as far back as December 1, 2012. The bulk of member benefit begin dates go back 120 days which means that 5,645 members may have utilized services (in and out of network) that will potentially generate a claim to CountyCare, yet CountyCare was not notified by the facility at the time of admission or discharge.

Table 5: Membership by Benefit Begin Date, 6/2014 Audit File

Benefit Begin Date	# New Members by Benefit Begin Date	# Total Members by Benefit Begin Date	Cumulative # Members by Benefit Begin Date	% New By Month
12/1/2012	-	97	97	0.00%
1/1/2013	-	585	682	0.00%
2/1/2013	-	1,961	2,643	0.00%
3/1/2013	9	2,579	5,222	0.35%
4/1/2013	4	3,537	8,759	0.11%
5/1/2013	5	8,057	16,816	0.06%
6/1/2013	5	8,156	24,972	0.06%
7/1/2013	1	9,222	34,194	0.01%
8/1/2013	8	8,690	42,884	0.09%
9/1/2013	10	7,788	50,672	0.13%
10/1/2013	7	8,025	58,697	0.09%
11/1/2013	54	4,405	63,102	1.23%
12/1/2013	91	4,871	67,973	1.87%
1/1/2014	266	5,920	73,893	4.49%
2/1/2014	263	4,989	78,882	5.27%
3/1/2014	373	6,456	85,338	5.78%
4/1/2014	383	5,888	91,226	6.50%
5/1/2014	3,124	4,735	95,961	65.98%
6/1/2014	2,470	2,515	98,476	98.21%
7/1/2014	382	433	98,909	88.22%
Total	**7,455**	**98,909**		**7.54%**

On 12/31/2013, County Care was granted a 90 day extension to continue to operate under the 1115 waiver demonstration project. However, under this extension, CountyCare was to be reimbursed PMPM from HFS at 100% FMAP instead of 50% FMAP for member months in 2014. For the payments in January and February 2014, HFS was unable to update their system and continued to pay PMPM at 50% FMAP. PMPM payment at 100% FMAP was restored in March 2014, and payment corrections for the January and February time periods were completed.

IX. Budget Neutrality

Table 6 below provides detail on the budget neutrality calculations for the waiver period.

Table 6: Waiver Period Budget Neutrality Calculation

Membership Year/Month	Members on 820 File	PMPM	Total $	State Share (Paid by Cook County)	FFP
2012/12	213	$625.45	$133,221	$66,610	$66,610
2013/1	1,342	$628.96	$844,064	$422,032	$422,032
2013/2	3,866	$628.96	$2,431,559	$1,215,780	$1,215,780
2013/3	9,256	$628.96	$5,821,654	$2,910,827	$2,910,827
2013/4	16,214	$628.96	$10,197,957	$5,098,979	$5,098,979
2013/5	25,900	$628.96	$16,290,064	$8,145,032	$8,145,032
2013/6	34,720	$628.96	$21,837,491	$10,918,746	$10,918,746
2013/7	44,601	$628.96	$28,052,245	$14,026,122	$14,026,122
2013/8	53,909	$628.96	$33,906,605	$16,953,302	$16,953,302
2013/9	62,116	$628.96	$39,068,479	$19,534,240	$19,534,240
2013/10	70,436	$628.96	$44,301,427	$22,150,713	$22,150,713
2013/11	74,741	$628.96	$47,009,099	$23,504,550	$23,504,550
2013/12	79,597	$628.96	$50,063,329	$25,031,665	$25,031,665
2014/1	84,768	$632.48	$53,614,065	$0	$53,614,065
2014/2	89,438	$632.48	$56,567,746	$0	$56,567,746
2014/3	95,099	$632.48	$60,148,216	$0	$60,148,216
2014/4	100,219	$632.48	$63,386,513	$0	$63,386,513
2014/5	101,727	$632.48	$64,340,293	$0	$64,340,293
2014/6	101,838	$632.48	$64,410,498	$0	$64,410,498
Total	**1,050,000**		**$662,424,526**	**$149,978,597**	**$512,445,928**

X. Customer Issues

During the course of the demonstration, CountyCare carefully monitored complaints from its members and sought to investigate and resolve all complaints. The complaints about patient access were of greatest concern and were monitored closely to ensure provider compliance with HFS access standards. CCHHS implemented several strategic initiatives to improve access that addressed scheduling, frequency of follow-up visits, nurse care management visits, etc.

A total of 532 complaints were received by members from project start through June 30, 2014. The reasons for these complaints fall into five major categories:

1. Complaint about access at PCP site (303/57%)
2. Complaint about CountyCare Program (97/18%)
3. Demographic Information Wrong for Approved Member (74/14%)
4. Information on Approval Letter Incorrect (37/7%)
5. CC representative (21/4%)

XI. Quality Assurance/Monitoring Activity

During the demonstration, CountyCare monitored its vendors through regular updates and

review of work completed. For example, the TPA produced regular reports on the call center, and utilization management (admissions, discharges, follow-up appointments, etc.), and reviewed them with leadership in weekly face-to-face meetings. Telephone performance and patient wait times to apply, check eligibility or benefits were monitored on weekly basis, and performance was within contracted standards.

CountyCare's Director of Operations implemented weekly meetings with all vendors supporting CountyCare operations. Routine reports covered membership data, call center operations, utilization, network development, membership grown and other key operational initiatives. Specific reports were requested and created to assist in making business decisions going forward, such as a claims history report.

In Year 2 of the demonstration, CountyCare began the transition to a new TPA, IlliniCare -- part of the Centene Corporation. As part of CountyCare's work toward achieving its goal of becoming a MCCN, CountyCare went through the State's Readiness Review through Health Services Advisory Group. CountyCare received a provisional green light to move forward. Beginning July 1, 2014, the new TPA initiated services.

XII. Demonstration Evaluation

An independent evaluation was conducted as part of the Special Terms and Conditions of the demonstration waiver; the state selected the University of Illinois to conduct this evaluation. Their report was released in April 2015. The report's goals and accomplishments, hypotheses, and evaluation findings are presented below.

Specific Goals and Accomplishments

The goal of the CountyCare waiver was to help the state and CCHHS build capacity and experience to support the transition to expanded Medicaid coverage under the Affordable Care Act in 2014. The specific goals of the waiver and the extent to which these goals were achieved are described below:

Goal 1: Provide health care coverage, over the course of the demonstration, to approximately 125,000 currently uninsured Cook County residents.

- *116,500 individuals were enrolled in CountyCare during the waiver period.*

Goal 2: Provide previously uninsured individuals with the additional benefit of mental health, substance use disorder services, and prescription services.

- *Behavioral health and pharmacy benefits managers were contracted by CountyCare to ensure access to these services on day 1.*

Goal 3: Ensure that services are provided in an effective and coordinated fashion through PCMHs that will ensure that appropriate services are provided in a cost-effective manner for this population.

- *The primary care network was built with the FQHCs serving as the backbone for*

member enrollment and care. As safety-net providers with highly integrated support programs and services, FQHCs are known for providing cost-effective care.

Goal 4: Provide comprehensive coverage for individuals not eligible for Medicaid or CHIP.

- *CountyCare benefits package mirrored that offered by IL Medicaid with the exception of additional rehabilitation services as discussed above.*

Goal 5: Expand the network of providers within the CCHHS network to ensure access to services for the demonstration population and build collaborations as the state prepares for expanded coverage in 2014. This demonstration will enable the state to study and evaluate trends in beneficiary needs, provider capacity, care delivery, and payment rates to assist in preparations for the implementation of provisions of the Affordable Care Act in 2014. This includes the coverage and payment for the group described in section 1902(a)(10)(A)(i)(VIII) for individuals under age 65, regardless of disability status, with income at or below 133 percent of the FPL.

- *The CountyCare provider network included over 160 primary care access points (all FQHCs and the CCHHS ambulatory clinics), 30+ community hospitals, all six major academic medical centers, and hundreds of ancillary providers.*

Hypotheses

The Waiver also specified that the state would test the following hypotheses in its evaluation of the demonstration:

- Expanding Medicaid services to the low-income adult population will improve the quality, coordination, and cost effectiveness of care at CCHHS.

- Expanding eligibility to the currently uninsured low-income adult population will jumpstart the enrollment process for the sub-group of individuals who will be newly eligible for Medicaid state plan benefits in 2014.

- Building partnership with community providers such as area FQHCs, mental health, and substance use providers will prepare the safety net for the substantial changes that will take place starting in 2014.

To test the hypothesis, an independent evaluation of the waiver was conducted by the University of Illinois at Chicago School of Public Health; a full report was released in April 2015. Researchers used the following methods for the evaluation: structured interviews with Cook County leadership at the County government level, CCHHS and County Care; focused surveys of point-of-care managers; analyses of multiple data sets; other interviews, focus groups, and surveys with smaller groups of CCHHS and CountyCare staff.

Evaluation Findings

- Enrolled 113,779 eligible individuals in the Medicaid program under the new eligibility category (during the 12/12 – 12/13 Waiver period);

- Expanded CCHHS healthcare delivery capacity by negotiating network provider contracts with a broad network of healthcare providers which expanded capacity by:
    - adding 141 FQHC sites to the existing CountyCare 17 ambulatory clinic sites (16 local and one regional),
    - adding 30 community hospitals including 2 teaching hospitals to the County Care CCHHS existing hospitals (Stroger and Provident),
    - adding over 100 physician specialists to the existing CountyCare capacity, and
    - adding numerous other medical and allied health practitioners as well as dozens of local pharmacies to the CountyCare provider network;

- Provided medically necessary care to 68% of the CountyCare newly covered individuals in the first 6 months of Waiver operation;

- Provided medically necessary care to 85% of the CountyCare newly covered individuals within the 12 months of Waiver operation;

- Expanded choice of a primary care medical home to include the existing CountyCare ambulatory clinic sites (17) as well as the 141 FQHC sites.

Lessons Learned

- Medicaid eligibility determination and enrollment was a lengthy process which could potentially be addressed in future large scale enrollment initiatives by developing various models of presumptive eligibility;

- Expanding the network of providers too quickly resulted in confusion with respect to referrals and intake across the provider network which could potentially be addressed in future large scale provider network development initiatives by timing staff training programs prior to any network referrals;

- Selection of a primary care physician and/or a healthcare professional team by the newly covered individuals was a positive step, in terms of having options to choose among (17 CCHHS sites and 141 FQHC sites). However, it also created a significant change in practice and delivery for the healthcare providers as well as the newly covered group, i.e., patients could previously seek care without regard to a specific clinic/site as well as seek care from any hospital emergency department (ED.) Therefore, the new CountyCare program was considered by some patients as inconvenient, while healthcare professionals could only marginally provide care coordination across network providers when they had no knowledge of the care provided to patients by other clinic sites and EDs. Care coordination appeared to be working within CCHHS clinic sites or within FQHC sites and its affiliated providers, but less so when patients were treated by multiple providers, which could potentially show the need for education and training for both Cook County healthcare professionals as well as the CountyCare participants.

- Projections regarding the profile of the newly covered individual's choice of a primary care medical home turned out to be inaccurate because the group selecting CCHHS providers was a group comprised of an older and more medically complex patient population as compared with the average newly eligible group who made other choices (possibly due to access to the specialty care including trauma, HIV/AIDS; and other highly specialized care).

- Assessing quality of care provided under CountyCare against HEDIS health plan measure proved to be a challenge given: (1) the short Waiver period; (2) the new CountyCare health plan implemented a managed care model, which, for the first time included a greatly expanded provider network, representing a nearly 10 fold increase in number of clinic sites; (3) a patient population accustomed to seeking care from free clinics and/or ERs regardless of location; and (4) practice transformation was evolving during the early stages of CountyCare and would not initially lend itself to traditional HEDIS measurement.

- Lastly, CountyCare strengthened some of their procedures and processes to improve the continued operation of this program including: (1) revising the contract with the state Medicaid agency to reflect formal status as an MCCN as permitted under state statutes; (2) entering into new agreements with the commercial IlliniCare Health Plan (Centene Corporation) to serve as its third party administrator; and (2) entering into an agreement with the Medical Home Network, Inc. to address EHR interoperability across the provider network.

XIII. Transition Plan

The State of Illinois submitted a transition plan document to CMS on December 9, 2013.

XIV. Additional Information

A. State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Teresa Hursey, Acting Administrator
Division of Medical Programs
Illinois Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, Illinois 62763
217-782-2570
217-782-5672 fax
Teresa.Hursey@illinois.gov

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