Minutes of the meeting of the Managed Care Committee of the Board of Directors of the Cook County Health and Hospitals System held Thursday, September 19, 2019 at the hour of 10:30 A.M. at 1950 W. Polk Street, in Conference Room 5301, Chicago, Illinois.

I. Attendance/Call to Order

Chair Thomas called the meeting to order.

Present: Chair Sidney A. Thomas, MSW and Directors Mike Koetting and David Ernesto Munar (3)

Board Chair M. Hill Hammock and Directors Mary Driscoll, RN, MPH; Ada Mary Gugenheim; and Layla P. Suleiman Gonzalez, PhD, JD

Absent: None (0)

Additional attendees and/or presenters were:

Debra Carey – Deputy Chief Executive Officer of Operations
James Kiamos – Chief Executive Officer, CountyCare
Jeff McCutchan –General Counsel
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief Executive Officer

II. Public Speakers

Chair Thomas asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Report on CountyCare Health Plan (Attachment #1) and
IV. Recommendations, Discussion/Information Items

A. Cook County Health (CCH) – Medicare Advantage Delivery Innovations Relationship (included in Attachment #1)

James Kiamos, Chief Executive Officer of CountyCare, provided an overview of the presentation regarding the Report on the CountyCare Health Plan and CCH – Medicare Advantage Delivery Innovations Relationship. The Committee reviewed and discussed the information.

The presentation included information on the following subjects:

- Metrics:
  - Current Membership
  - Managed Medicaid Market
  - Medicaid Managed Care Trend
  - Claims Payment
  - Overall Care Management Performance
  - Overall Member Age Distribution
  - Affordable Care Act (ACA) Member Age Distribution
- Medicare Advantage
  - Medicare 101
  - Traditional Medicare vs. Medicare Advantage
  - Medicare Advantage Market
  - Age-In Populations and Continuity of Care
  - Medicare Advantage Partnership
  - Medical Home Network (MHN) Partnership
  - Relationship between MHN and Medicare Advantage Delivery Innovations d/b/a MoreCare
  - MoreCare Health Plan Launching in 2020

- Division of Responsibility Structure
- Timeline of Initiative
- Financial Assumptions
- Medicare Pro-Forma Summary
- Key Activities
- Medicare.gov Star Rating
- Keys to Success

V. Action Items

A. Minutes of the Managed Care Committee Meeting, June 20, 2019

Director Koetting, seconded by Director Munar, moved to accept the minutes of the Managed Care Committee Meeting of June 20, 2019. THE MOTION CARRIED UNANIMOUSLY.

B. Any items listed under Section V

VI. Adjourn

As the agenda was exhausted, Chair Thomas declared the meeting ADJOURNED.

Respectfully submitted,
Managed Care Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXX
Sidney A. Thomas, MSW, Chair

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Requests/Follow-up:

There were no requests for follow-ups.

ATTACHMENT #1

CountyCare Update

Prepared for: CCH Managed Care Committee

James Kiamos

CEO, CountyCare

September 19, 2019

Board Metrics

CountyCare HEALTH PLAN

Current Membership

Monthly membership as of September 6, 2019

Category	Total Members	ACHN Members	% ACHN
FHP	211,329	17,244	8.2%
ACA	71,926	13,130	18.3%
ICP	29,552	5,927	20.1%
MLTSS	6,008	0	N/A
Total	**318,816**	**36,301**	**11.4%**

ACA: Affordable Care Act
FHP: Family Health Plan
ICP: Integrated Care Program
MLTSS: Managed Long-Term Service and Support (Dual Eligible)

Managed Medicaid Market

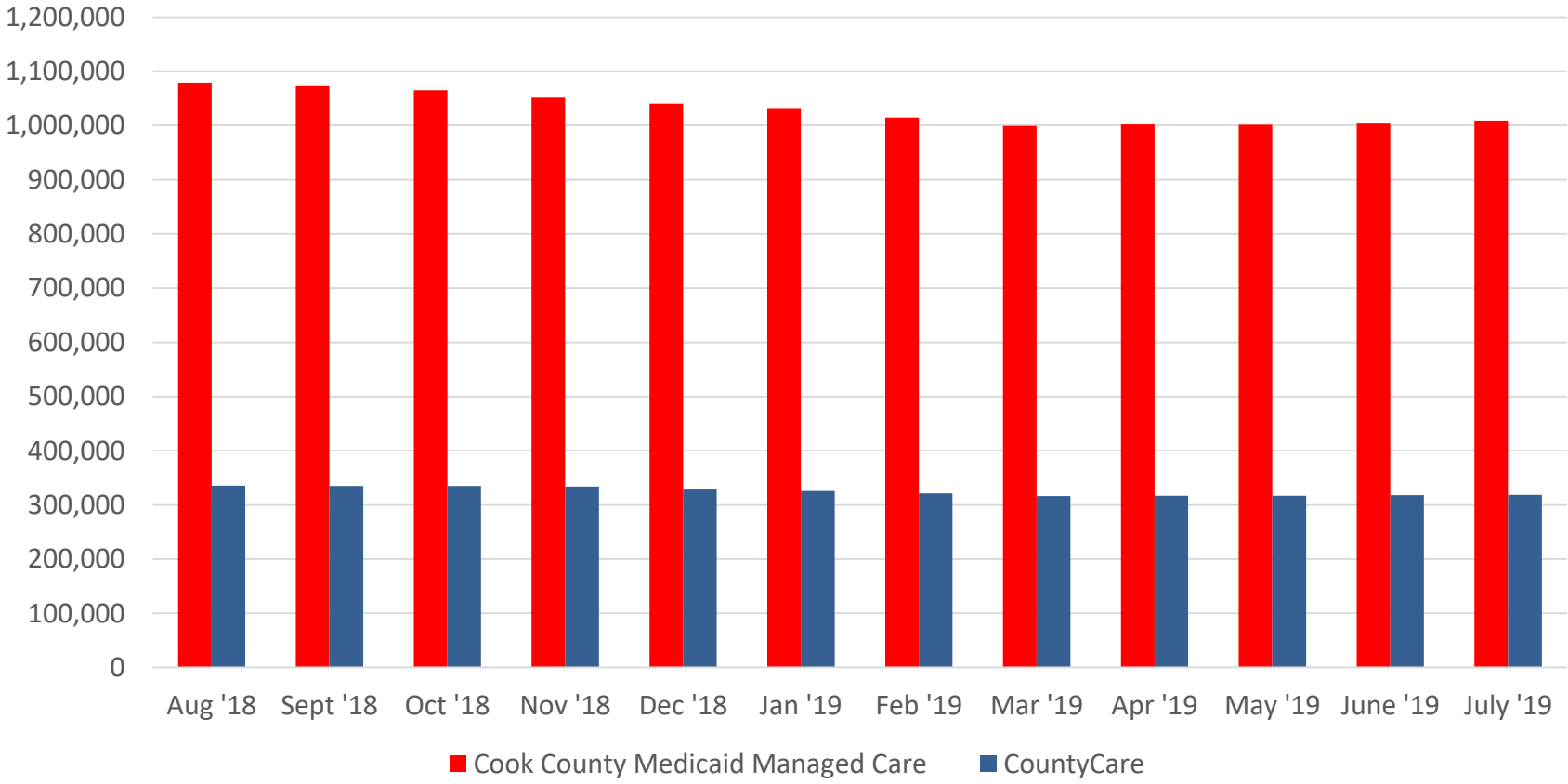
Illinois Department of Healthcare and Family Services July 2019 Data

Managed Care Organization	Cook County Enrollment	Cook County Market Share
*CountyCare	318,207	31.6%
Blue Cross Blue Shield	235,707	23.4%
Meridian (a WellCare Co.)	229,757	22.8%
IlliniCare (a Centene Co.)	110,390	11.0%
Molina	66,139	6.6%
*Next Level	47,853	4.7%
Total	**1,008,053**	**100.0%**

* Only Operating in Cook County

Meridian and WellCare (dba Harmony) merged as of 1/1/2019. Pending Merger with Centene (dba IlliniCare)

Medicaid Managed Care Trend



2019 Operations Metrics: Claims Payment

Key Metrics	State Goal	Performance		
		May	Jun	Jul
Claims Payment Turnaround Time				
% of Clean Claims Adjudicated < 30 days	90%	95.9%	97.4%	97.4%
% of Claims Paid < 30 days	90%	44.0%	40.7%	44.9%

2018-2019 Operations Metrics: Overall Care Management Performance

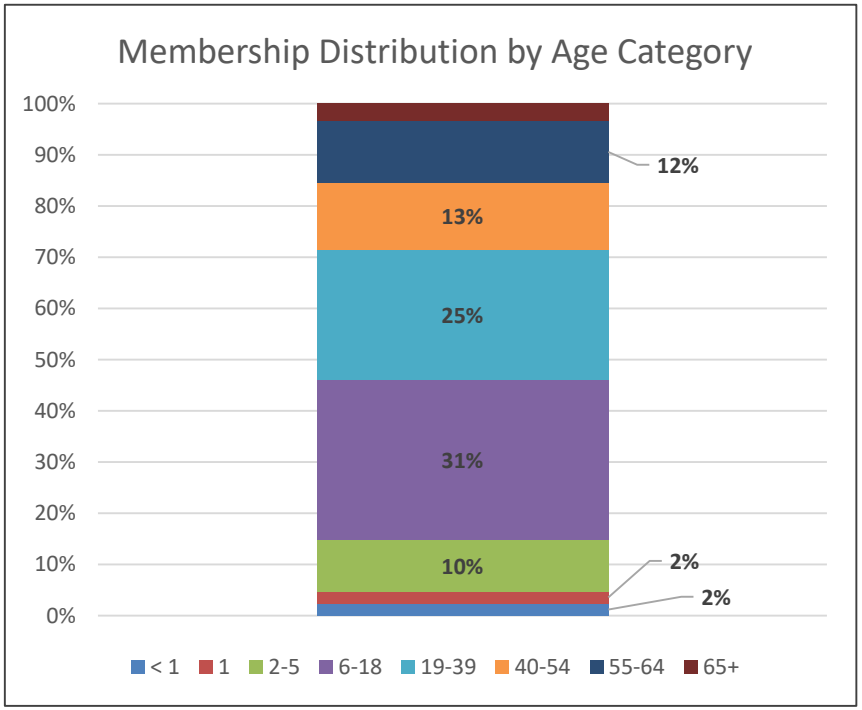
Key Metrics	Market %	Performance		
		May	Jun	Jul
Completed HRS/HRA (all populations)				
Overall Performance	40%	63.0%	63.3%	64.6%
Completed Care Plans on High Risk Members				
Overall Performance	65%	61.9%	61.5%	61.7%

CountyCare's high-risk percentage exceeds the State's requirement of 2% for Family Health Plan and 5% for Integrated Care Program

Overall Member Age Distribution

Age Category	Membership
< 1	7,946
1	8,119
2-5	33,625
6-18	105,896
19-39	85,131
40-54	44,609
55-64	40,168
65+	11,557

Average Age = 27.1 years



ACA Member Age Distribution

Age Category	Membership
19-39	35,772
40-54	22,179
55-64	23,315
65+	1,013

Average Age = 42.5 years

ACA: Affordable Care Act

Medicare Advantage

Medicare 101

- **Traditional Medicare (Also known as Original Medicare)**
  - Original Fee-for-Service government program with no specified network, no care management, no supplemental benefits. Part D for prescription drugs is purchased separately.
- **Medicare Supplement**
  - Optional private insurance purchased in conjunction with “traditional” Medicare to cover benefits/costs not covered by the government program.
  - Typically has a premium of $75+ per month, which is often considered too costly for low income beneficiaries. Part D is purchased separately.
- **Medicare Advantage**
  - Private insurance alternative to traditional Medicare; Offered by private companies that have a contract with The Centers for Medicare & Medicaid Services (CMS)
  - Covers CMS-defined benefits plus **supplemental benefits** that go beyond Medicare
  - Typically includes **care management, disease management, and other programs aimed at keeping people healthy**

Traditional Medicare vs. Medicare Advantage

BENEFIT COMPARISON	ORIGINAL MEDICARE	MEDICARE ADVANTAGE
Doctor visits	✓	✓
Hospital stays	✓	✓
Monthly plan premium	✓	
Deductible on doctor and hospital visits	✓	
Predictable out of pocket costs		✓
Part D – drugs coverage		✓
Dental		✓
Vision		✓
Hearing		✓
Transportation		✓
Over The Counter (OTC) card		✓
Healthy Food*		✓
Gym membership*		✓

*Included in some Medicare Advantage plans

Medicare Advantage Market

- Growing amount (828,439) of Medicare beneficiaries in Cook County
- Current Medicare Advantage (MA) market penetration is 27% compared to national average of 33%
- Market penetration has been growing steadily in Cook County and nationally
- Top 5 plans in market represent 77% of total market share with no single dominant player

Age-in Populations and Continuity of Care

- Aligns with Strategic Plan
- Within CountyCare and Cook County Health
  - Significant Medicare populations in 2020
  - Every year thousands of CountyCare members “graduate” into Medicare
  - Cook County Health system has 14,000 Medicare patients currently being served
  - This will allow us to maintain these patients as Medicare Advantage expands

Medicare Advantage Partnership

- **Initially explored solo path**
  - Requires Illinois Department of Insurance licensure
  - Did not meet certain requirements
- **Alternate strategy of partnership**
  - CCH Health Plan Services retained as contractor
  - Paid percent of premium to manage risk of members
  - Perform health plan services under a contract
  - Non-exclusive arrangements

Medical Home Network Partnership

- Cook County Health (CCH) and Medical Home Network (MHN) have been partners since CountyCare's inception

- **Shared Foundation**
- **CCH has a 180 year history** of providing access and quality care to all Cook County residents
- **MHN was founded in 2009** by the **Comer Family Foundation** to transform healthcare delivery for the Medicaid population

- **Unparalleled experience**
- Understanding the **whole-person needs** of Cook County's underserved residents
- Redesigning health care delivery and care management for the safety-net
- Building **patient relationships** beyond 4 walls of practice
- Achieving better health **outcomes**, **costs** and **engagement** – outperforming other Medicaid programs

Relationship between Medical Home Network (MHN) and Medicare Advantage Delivery Innovations (MADI)/dba MoreCare

- MHN a not for profit 501c3 whose mission is to transform healthcare and reduce disparities in the safety-net.
- MADI/dba MoreCare a fully owned subsidiary of MHN.
- MADI established as a for profit to enable access to capital if needed.
- MHN ACO is an LLC owned by the 13 safety-net providers. It is managed by MHN, but MHN has no ownership of the entity—only the providers own it.
- MHN ACO is a high performing longstanding provider partner of CountyCare

MoreCare Health Plan Launching in 2020

MoreCare®

A Medical Home Network Affiliate

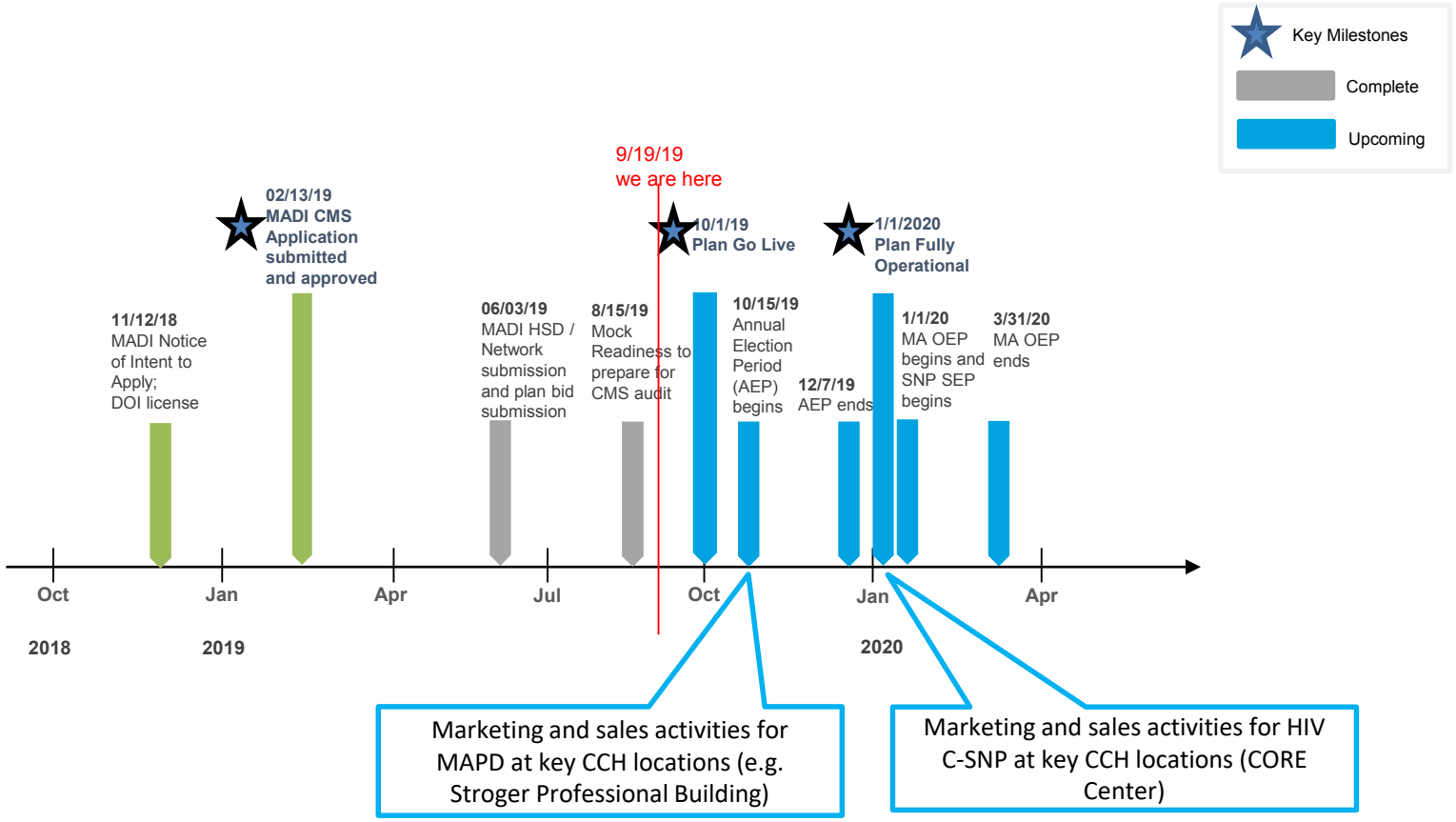
Products Overview

MoreCare For You	**General Medicare Advantage Plan with Prescription Drugs (MAPD)**	• Any Medicare-eligible beneficiary
MoreCare Home	**Institutional Special Needs Plan (I-SNP)**	• Any Medicare-eligible person who lives in an institution (e.g. nursing home)
MoreCare At Home	**Institutional Equivalent Special Needs Plan (IE-SNP)**	• Any Medicare eligible person who lives at home but requires nursing level of care
MoreCare +	**Chronic Condition Special Needs Plan for HIV (C-SNP/HIV-SNP)**	• Any Medicare eligible person with a diagnosis of HIV

Division of Responsibility Structure

Area of Focus	MADI	CCH
CMS Contract Holder	✓	
IL Insurance License	✓	
Marketing & Sales	✓	
Compliance	✓	
Health Plan Operations		✓
Program Development	✓	✓
Provider Network		✓
Health Plan Policy		✓
Finance	✓	✓
Benefits Design		✓
Actuarial Services		✓
Delegated Care Management		✓
Vendor Management		✓

Timeline of Initiative



Financial Assumptions

- A strategy evaluation 5 year pro forma was developed after the initial Sr. Management Meeting on 07/27/18 in which Board members also were invited to attend.
- Medicare requires investment in upfront resources to ensure compliance with all CMS requirements.
- Estimated break-even membership is 5,375.
- At 10,000 lives, we expect a net surplus of greater than $7 million annually.

Financial Assumptions

- First year membership enrollment target is 1,250.
- Plan is expected to realize additional financial benefit to Cook County Health from utilization occurring at Cook County Health facilities.
- The pro forma assumes similar in-house utilization assumptions as is being achieved within CountyCare.
- Medicare provider network is a much smaller subset of the current Medicaid network.

Medicare Pro-Forma Summary

Medicare Pro-Forma Summary						
	2019	Year 1 - 2020	Year 2 - 2021	Year 3 - 2022	Year 4 - 2023	Year 5 - 2024
Membership		1,250	3,000	5,000	7,500	10,000
Revenue	$ -	$ 24,919,757	$ 56,888,320	$ 93,884,370	$ 140,005,277	$ 187,933,467
Administrative Expense	$ (7,840,728)	$ (9,420,517)	$ (11,366,967)	$ (15,099,242)	$ (18,569,813)	$ (20,429,692)
Medical Expense (External and Internal)	$ -	$ (21,181,793)	$ (48,355,072)	$ (79,801,714)	$ (119,004,486)	$ (159,743,447)
Profit/Loss	**$ (7,840,728)**	**$ (5,682,554)**	**$ (2,833,719)**	**$ (1,016,586)**	**$ 2,430,978**	**$ 7,760,328**
Internal Medical Expense	$ -	$ 4,236,359	$ 9,671,014	$ 15,960,343	$ 23,800,897	$ 31,948,689
CCH Net Contribution	**$ (7,840,728)**	**$ (1,446,195)**	**$ 6,837,296**	**$ 14,943,757**	**$ 26,231,875**	**$ 39,709,018**

Key Activities

- Finalize and implement key vendors
  - Establish a strong operational plan with these key vendors
  - Establish meaningful operational oversight of key vendors
- Recruitment and staffing to successfully launch products
  - Within MADI
  - Within CCH Health Plan Services
- Network adequacy criteria
  - Provider contracts completed and providers credentialed before submission to CMS
  - CMS review and determination that the provider network meets full adequacy

Keys Activities

- Benefits, Plan design and bid and Formulary
  - Contract for extra benefits
  - Submission to CMS
- Marketing Plan
  - Finalize sales strategy
  - Hire/contract and train sales force
  - Develop and get approval for marketing materials, enrollment forms, marketing presentations, provider directories

Medicare.gov Star Rating

- **Overall Star Rating** gives an overall rating of the plan's quality and performance

- **Five Key Areas**
  - **Staying healthy: screening tests and vaccines:** Whether members received various screening tests, vaccines, and other check-ups to help them stay healthy.
  - **Managing chronic (long-term) conditions**: How often members with certain conditions got recommended tests and treatments to help manage their conditions.
  - **Member experience with the health plan**: Member ratings of the plan.
  - **Member complaints and changes in the health plan's performance:** How often members had problems with the plan. Includes how much the plan's performance improved (if at all) over time.
  - **Health plan customer service**: How well the plan handles member calls and questions

- **Pharmacy (Part D) Stars are also Critical**

Keys to Success

- Getting membership to scale quickly
- Plan is expected to realize additional financial benefit to Cook County Health from utilization occurring at Cook County Health facilities
- The pro forma assumes similar in-house utilization assumptions as achieved within CountyCare
- Medicare provider network is a much smaller subset of the current Medicaid network

Keys to Success

- **Stars**
  - Significant implications to revenue and growth
  - Work in year one has significant impact on Initial Star rating, which is published in 2022
  - Affected by multiple parts of the organization

- **Risk Adjustment**
  - Significant implications to revenue; can be used as a good tool for medical management
  - Work each year has significant impact on future years

- **Provider Engagement**
  - Value based payments
  - Support