Comments to: The Coordinated Care Program-Key Policy Issues

1. How comprehensive must coordinated care be?

First I would like to comment to the legislation states a patient-centered medical home with a primary care physician and referrals from the primary care physician.

A. **It is essential that this be provider neutral to include APNs as a provider for patient-centered homes. More and more physicians do not accept Medicaid leaving a great number of patients without a provider. APNs are independent providers under the Medicaid program and it is paramount that they be included as the providers of the medical homes for their Medicaid population without reliance on a physician.**
B. Whatever the requirements are required for a provider contract depends on the elements of the contract whether starting with a base and gradually increasing all depends on the elements under consideration
C. No certification for medical homes should be required. Under Illinois Health Connect, patients are assigned or choose a provider/medical home. The medical home provider is responsible for coordination of all the patient care for each Medicaid enrollee and all referrals should be generated from that provider. Medical homes should be required to be operational "x" number of hours per week, provide coverage for absences (conferences/vacations), and be accountable for each patient's care in the Medicaid/medical home system as is for all patients. As the primary provider of a Medical home, it is the provider's responsibility to coordinate the patient's care and generate any referrals as deemed necessary. This eliminates "provider hopping", patients getting their own appointments, etc. which therefore controls cost of patient care.
D. Yes. An enrollee should be required to choose their provider as their medical home, but allowing one change per year of provider if that relationship between provider and patient is not optimal to the coordination of care.
E. No umbrella coverage including a master pharmaceutical contract for patients. Those type services are not available in each part of the state or to all enrollees.
F. Benchmark bonus payments similar to Illinois Health Connect.

2. What should be appropriate measures for health care outcomes and evidence based practices?
   A. Annual physicals, pap smears, mammograms, well checks on child age groups, immunizations, specific disease management goals (Hemoglobin A1c, lipids, etc.).
   B. Must be different measures for different clients. The measures must be age appropriate
   C. Risk adjustment has to be coordinated on both the client and provider field with easy access to problem solving coordinators for both sectors.
   D. Focusing initially on well check benchmarks and chronic disease management goal attainment

E.

F. Develop a panel of Medicaid providers that is provider neutral to include all primary care providers.

G. Success is measured by attainment of benchmarks.

3. To what extent should electronic information capabilities be required?
    A. Communication through billing can be attained for well check/preventive exams. Benchmarks for chronic disease goal attainments can be coded.
    B. No. Unless EHR systems become universal and there is substantial incentive to initiate, most practices unless associated with large institutions will not be able to afford such systems.
    C. No incentives for HER. No trade-offs. Outcome incentives are paramount to patient care and well-being than electronic health records.
    D. No time frame required. Lowering base rate for no electronic health records will force many providers to cancel their participation leaving patients at risk for health care.

4. What are the risk-based payment arrangement that should be included in care coordination?
    No discussion on risk based arrangements, medical loss ratio or risk adjustment for providers. Quality care is a goal for patient care with no limits to complex conditions.

5. What structural characteristics should be required for new models of coordinated care?
    A. Medicaid has a system in Illinois Health Connect for models of care. Medicaid should contract with all entities willing to participate
    B. No arrangements or certification needed
    C. No minimum number of enrollees are required as each medical home can increase their patient base as patient's are assigned or choose to be assigned.
    D. The providers must be "provider neutral". Physicians only language is not acceptable as Nurse Practitioners and Certified Nurse Midwives are recognized as independent Medicaid providers. Access to specialty care should be coordinated by the medical home provider.
    E. Nice idea, but who determines who is the "difficult client"?

6. What should be the requirements for client assignment?
    A. Client choice is practical
    B. Geographic area
    C. Limit number of enrollees is possible. If a provider/patient relationship is not a "good fit", the patient and provider should each have an opt-out of that relationship.
    D. Auto assign among the group of available providers with option to change providers by phone request

E. A Provider should not be allowed to get a larger proportion of auto-assignees over any other provider willing to take assigment.
F. Two years before switching to a more experienced based formula
G. No lock in for clients but allowing for one provider exchange in a year's time only eliminating changing providers every month.
H. Offer opportunities to current medical homes of Illinois Health Connect
I. Same as current

7. How should consumer rights and continuity of care be protected?
   A. Use of all provider entities for coordinated care homes for the Medicaid population.
   B. Same as Medical Home model
   C. Yes
   D. Patients can be allowed to continue or make 1 change per year for medical home relationships.
   E. What client information for plan quality and appeal rights? By patient or medical home?

8. What is your organization's preliminary anticipation of how it might participate in coordinated care?
   A. The first thing that must happen is remove the physician language of this legislation therefore allowing APNs to serve as medical homes to this coordinated care program. APNs are professional providers of health care and have been shown in studies to provide quality care to patients. Unless APNs are independent providers of this endeavor-there will be severe limitations of access to healthcare in many areas of the state
   B. Illinois Health Connect open to all willing providers eliminating physician language and making it "any willing provider" or provider neutral language.
   C. APNs are independent Medicare providers-independent of physicians.
   D. I am a medical home for Illinois Health Connect as a nurse practitioner independent of a physician. My medical home will be ready in 2013. Personal only.
   E. Unlimited clients for primary care and chronic disease management. Personal comment- I manage an aggressive lipid clinic for primary and secondary cardiovascular risk reduction with an estimated goal attainment of 85% for all patients with dyslipidemia, diabetes and hypertension as well as those with previous history of cardiovascular disease.

Some of my comments represent my own responses as well as responses for the Advanced Practice Nurses of Illinois. I would welcome an appointment to the panel in determining benchmarks, disease maintenance and goal attainment planning.

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