

La Rabida Children's Hospital
Response to DHFS RFI for Comments on Care Coordination

June 29, 2011

La Rabida Children's Hospital is extremely pleased to have the opportunity to respond to the Department of Healthcare and Family Services' Request for Information related to policy questions for the proposed Coordinated Care Program. We expect that DHFS will build on successes of other states and will build on assets in Illinois to develop a program that provides high quality care to all patients, that adequately subsidizes the costs of providing and coordinating care, and that ultimately reduces net costs to the Medicaid Program.

La Rabida Children's Hospital offers high-quality, patient-centered care to over 8,000 unique children from the greater Chicago region each year. Our medical home practice for children with special health care needs serves approximately 4,000 unique children annually. Using an interdisciplinary model, these medical homes offer programs for infants born prematurely, children and adolescents with developmental delays and/ or chronic conditions, and for children dependent on medical technology. La Rabida recently became the first Illinois provider of care to children with complex medical needs to be recognized by the National Committee for Quality Assurance (NCQA) for this special medical home model.

La Rabida has a long history of investing in the needs of the children, especially children with complex needs. Children with complex medical conditions and/or difficult sociologic issues need a higher level of investment. La Rabida has invested in social workers, nurses trained in coordinating care and other health care professionals with expertise in working with these populations. We have a talented, committed and coordinated staff focused on the needs of children especially children with complex medical needs.

Since 89 percent of La Rabida's patient revenue comes through Medicaid, DHFS's Care Coordination plans are especially relevant to our institution. We look forward to the transition to a payment environment that more directly supports the complex and critical work that La Rabida performs for this population. We are confident that DHFS is interested in continuing to support the viability of critical institutions such as La Rabida. We commend DHFS for proposing the Care Coordination program and its desire for integrated, coordinated care for all Medicaid beneficiaries. Since our particular focus is children with complex medical needs and their families, we will limit most of our comments to this population.

The development and implementation of care coordination services, as well as the testing of different financial models, will take time and financial support. To develop a set of workable models for the State, we recommend testing a model of care coordination with varying levels of service, based on the complexity of the target populations. We believe that different financial models for care coordination will need to be tested, starting with bonus payments for meeting care coordination standards and moving to

varying levels of financial risk for the populations. We expect there will be focus on particular target populations and/or specific geographic regions rather than a whole scale expansion of a “one size fits all” approach. From this base we offer our comments.

1. *How comprehensive must coordinated care be?*

Questions for Comment

- a) Do you think that coordinated care should require contracts with specific entities that arrange care for the entire range of services available to a client via Medicaid, across multiple settings and providers? Are there any alternatives you would recommend for consideration?

A coordinated delivery system will require care coordination over a range of services and across disparate entities. The medical home, through formal collaboration with an organized arrangement of specialist and diagnostic services, and hospitals and other services, should have primary responsibility for coordination of care within and between systems. Some healthcare facilities may be well positioned to serve as regional coordinators of care for a specific population, such as La Rabida for children with complex needs. Within more comprehensive models of care delivery, provider driven ACOs including those specifically focused on children, are another option to consider. Alternatively, for more general populations, regional non-profit organizations (e.g., Medical Home Network in Chicago) could serve as facilitators of care coordination for larger geographic regions. Regional care coordination has been successfully demonstrated in the Medicaid population through the Community Care of North Carolina.

- b) Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time, i.e. start with a base set of requirements and gradually increase over time?

Sufficient time and support should be given to providers to meet requirements for broad provider participation and to reduce the need for patients to change providers. If providers of care coordination services cannot meet requirements in a reasonable period of time, they would need to be excluded from the program.

- c) Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operationalized? Would existence of a medical home require NCQA certification? Would all primary care physicians be required to be in practices that meet these requirements? What requirements are essential for every practice? Presumably it would be possible to increase requirements over time. What progression would make most sense?

A certification process requires institutional commitment and formal certification provides a framework for enforcing basic requirements. La Rabida is proud to be NCQA recognized but also

realizes that, while beneficial and noteworthy, a recognition or certification process is not sufficient in and of itself. Not everything measured by NCQA is essential, and some activities and infrastructure that we think work well for coordinating care may not be sufficiently measured in NCQA's model, particularly for children with special health care needs. We believe NCQA recognition should be considered and we strongly propose the use of recently published NCQA Care Coordination measures as a starting point for determining care coordination standards for the State. In addition to the NCQA care coordination standards, children with complex needs would require coordination with home health care, school, early intervention and other health and social service agencies; we would strongly recommend that representatives from health care facilities currently providing care coordination in a medical home setting for this population, such as La Rabida, be represented on any advisory committee or workgroup charged with developing these standards. The workgroup should review elements of various medical home models nationally and build on the State's PCCM medical home requirements. We would recommend audits be conducted to ensure that practices are meeting the care coordination requirements.

- d) How explicit should requirements be about how an entity achieves coordinated care? For instance, should the care coordination entity be required to assign an integrator or care coordinator to each enrollee?

We would recommend that a patient be assigned to a provider-led, medical home team with one or more persons on the team fulfilling the care coordination functions. We would recommend that practices have the choice of designating a specific care coordinator to particular patients or distributing specific tasks among the team collectively. For example, a medical assistant might be charged with referral tracking for all assigned patients, while a nurse may be charged with handling transitions of care for those patients. We believe the assignment of a medical home provider for each enrollee should be sufficient.

- e) Where, if at all, should HFS provide some kind of umbrella coverage for entities, e.g. negotiate a master pharmaceutical contract that would be available to all coordinated care entities?

Any help at securing lower costs would be useful for all models of care coordination utilized. However, the precise form and requirements of use should depend on the level of risk assumed.

- f) What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?

Provider participation is directly affected by the current very low Medicaid payment rates in relation to commercial rates. This directly affects patients securing appropriate services. Additional new revenue would greatly help. However, any new money must be tied to timely physician availability and performance. New payments for care coordination services adjusted for patient complexity could incentivize providers to conduct care coordination functions which

should free up money currently consumed through uncoordinated care delivery; better coordination should yield fewer services that could then be used to increase the rate paid for services (likely best through incentive type payments). Nevertheless, in the short run, new revenue is likely needed to “prime the pump”. Resources for regional non-profit organizations (like the MHN) to build/maintain infrastructure (e.g., web-based bi-directional communication) to enable more efficient communication and care coordination between health care facilities may also incentivize providers to participate in a coordinated care network by reducing some their expenses associated with fragmented care and thereby encourage participation.

2. *What should be appropriate measures for health care outcomes and evidence-based practices?*

Questions for Comment

- a) What are the most important quality measures that should be considered?

The new NCQA PCMH recognition program uses 3 primary domains of care coordination with a total of 25 measures; we think this shows a lot of promise as potential core measures for quality of care coordination. For children with complex health care needs, additional parent experience measures that address care coordination including review and receiving current care plans would be important. We would recommend exploring the use of nationally recognized patient/parent experience surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS is currently developing and rigorously testing a patient experience survey specifically for use in patient centered medical homes. Other national efforts should be strongly considered such as the pediatric quality measures currently in development in Illinois by DHFS and supported by a grant from the Children’s Health Insurance Program Reauthorization Act (CHIPRA).

- b) Is there one set of measures that should be applied to all coordinated care or might there be different measures for different kinds of clients--for instance, children versus adults or disabled versus non-disabled?

All three of our suggestions above would be relevant for all populations; however, the care plan is most relevant for persons with complex health conditions. The denominators used to determine performance rates will need to be adjusted for special populations (e.g. children diagnosed with a severe developmental delay do not need further screenings for developmental delay or children who have spent a significant portion of their first year of life in a NICU not actually having required “well-child” physician visits).

- c) How should the Department think about client risk adjustment in order to level the playing field as providers deal with patients across a wide range of situations?

It is important for making comparisons across providers and for fair payments that a risk-adjustment methodology be used to take into account patient condition complexity/severity, as well as sociologic measures. La Rabida developed a preliminary approach to risk-stratification for this population in the context of care coordination and presented it to DHFS earlier this year. We believe such a risk adjustment approach is critical and La Rabida is very interested in assisting DHFS in developing the methodology for children with special healthcare needs.

- d) What kind of guidance is available concerning the number of measures that would make sense, especially since coordinated care covers a broad spectrum of care?

We believe global measures of patient experience and care coordination are most appropriate as a core set of measures as recommended above. As discussed above, measures would need to be risk-adjusted due to the nature of particular conditions. Specific measures should also be developed for targeted populations. For example, readmission rates for children dependent on ventilators may be very different than for many other populations.

- e) What percentage of total payment should be specifically tied to quality measures?

We would encourage building on the current system where providers are rewarded within the PCCM program for high performance related to specific care processes. We believe risk arrangements come with challenges and unintended consequences and would recommend starting a few targeted areas of performance and care.

- f) How can the Department most effectively work with other payers to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?

It appears a multi-payer initiative takes legislative action and will not likely be accomplished through voluntary means alone. However, please note: some providers are currently engaged voluntarily in developing measures similar to what is being proposed here with several commercial payers. Their insights should be sought wherever possible so integrated measures can be developed across payers as appropriate.

- g) How will we know when we have achieved care coordination, i.e. how should we measure success?

Success would be achieved when an assessment, such as an adapted NCQA care coordination tool, indicates that a practice demonstrates test tracking and follow-up, referral tracking and follow-up, and that the practice systematically coordinates with facilities and care transitions; and that patients/families report good experiences with care and care coordination. Experiences of parents of children with special health care needs would need to include regular review and receipt of a

care plan, coordination with home health and social services, school programs, etc. Resulting cost savings are important measures of success. A methodology would need to be developed to measure changes in Medicaid expenditures for services and ultimate net savings of the Program.

3. *To what extent should electronic information capabilities be required?*

Having an integrated electronic health record that is available between providers, payers and patients is a desirable and ultimately critical component of offering comprehensive care coordination. The question really is how quickly and how uniformly should this be pursued.

To achieve Level 3 Medical Home recognition from NCQA an electronic medical record is a critical requirement. But even in this recognition process it is not an essential requirement since there are other means that enable providers to communicate between organizations, manage information, and provide care coordination services. Until Health Information Exchanges (HIE's) are established and Meaningful Use funding has been allocated to providers, electronic information capabilities should not be an initial requirement for care coordination. Entities should demonstrate their commitment by participating in collaboratives that are developing communication systems and information exchanges and be able to meet communication and coordination standards that are necessary to demonstrate care coordination and measure health outcomes.

Questions for Comment

- a) What type of communication related to the clinical care of a Medicaid client should be required among providers until electronic medical records and health exchanges become ubiquitous?

Providers must perform (electronically or otherwise) the core functions described in other answers: effective communication of a care plan to the family and other providers participating in the care of the patient, communication of results of tests and referrals, and communication to and from emergency rooms and hospital inpatient units to and from the medical home.

- b) Should the Department offer bonuses for investments in EHR systems, above the substantial incentives from ARRA?

Such bonuses are unlikely to be sufficient in size to warrant the investment in the necessary oversight. Funds should be directed at supporting care coordination outcomes and reimbursement rates for clinical services as mentioned earlier.

- c) If additional incentives were going to be added for being electronically enabled, that would inevitably mean less reimbursement somewhere else. How important are incentives above and beyond the ARRA incentives to induce electronic connectivity? What trade-offs would be appropriate to support such incentives? (For instance, should the amount of money available for outcome incentives be

reduced to increase these incentives? Or should there be a lower base rate with specific incentives for increasing connectivity?)

Though we recommend against specific money directed to EHR systems, we believe the zero sum gain outlined in the question (is this investment or in any other specific investments) is not necessary. For instance, increased federal match rates ought to be used for two years to support coordinated care and the funds from this increased federal match rate ought to be directed towards building capacity to cement the transition to more coordinated care.

- d) On what time frame should we expect all practices to be electronically enabled? How would we operationalize the requirements? Is tying them to the official "meaningful use" requirements sufficient?

Meaningful use is probably sufficient. The important thing is for practices to get the right outcomes. If the outcomes are correctly identified, becoming electronically enabled will be naturally necessary to perform well.

4. What are the risk-based payment arrangements that should be included in care coordination?

La Rabida firmly supports provider sponsored and initiated Care Coordination. And yet, we acknowledge that most providers are not experienced in, nor ready for, full risk payment arrangements. In fact, in many situations, particularly where multiple levels of care coordination were attempted, many provider-sponsored organizations failed to survive economically. As a result, an orderly, step-by-step process for moving from the historical discounted fee-for-service (with some "block-grant-type" payments (supplemental hospital payments) to "essential" providers) to a structure whereby providers assume more full risk is strongly suggested. And prior to moving from one step to the next, essential Medicaid provider entities must show not only specific clinical outcomes but also economic stability measures. For without both aspects progressing positively together, patients will either not receive the care they deserve or the delivery system needed to provide that care will further erode.

The fact that a Care Coordination approach is being developed at the same time that a major revision in the hospital tax and payment system is being formulated makes the need for orderly and thoughtful implementation of payment structure changes that much more important. This level of uncertainty places essential providers in a vulnerable financial situation, causing them to react with caution and concern. The fact that these providers have historically often been underfinanced by Medicaid limits their ability to assume risk at a rapid pace.

Questions for Comment

- a) How much risk should be necessary to qualify as risk-based?

Ideally, “risk-based” payment structures generally have a purpose: to bend the cost curve while delivering high quality care and patient experience. However, too much risk could have unintended consequences--either patients will not receive the care needed or providers will collapse because of not enough financial support. A near perfect risk adjustment process is essential at the time of enrollment. Without this prospective risk adjustment, the State will not get the intended consequences but rather an environment of avoidance of the “difficult” populations and a downward spiral of financial punishment for those institutions that follow a mission of serving “difficult” populations. The right risk approach entails a multi-year plan that slowly increases the amount at risk with early incentives to build the infrastructure needed to bend the cost curve.

A second type of “risk” also deserves mention. Since Medicaid generally pays less than most providers’ costs, simply expanding access at current rates places many providers “at risk” for serving more Medicaid patients especially physicians and diagnostic services. Getting them to coordinate this care without additional payments exacerbates these issues. As such, expanding access at existing fee-for-service rates may be too much risk for many essential providers. As a result, any form of additional risk assumption should be evaluated within the context of that provider’s full scope of business across all payers---for some, significant expansion should be allowed, for others, significantly less. DHFS should establish mechanisms to assist providers in evaluating the amount and structure of risk assumed. Without continued provider existence and participation, DHFS may fail to have an adequate delivery system to provide the care needed for the Medicaid population.

- b) Could "risk-based arrangements" include models with only up-side risk, such as pay-for--performance or a shared savings model? But if it's only up-side risk, is there any "skin in the game", without something to be lost by bad performance?

As stated in the answer above, below cost payments place many providers “at risk” from the get-go for treating more patients; one could readily argue that they already have enough “skin in the game” without assuming more. The issue is more constructively framed as “what appropriate use of and quality of service does one provide for the payment received?” Without safeguards to assure appropriate use, then the more “risk” one assumes the more likely inappropriate (low) service will be provided allowing more capitation (risk) payments to be retained by the provider.

- c) If initially included, over what time frame should these arrangements be replaced with the

acceptance of down-side risk?

In an orderly progression, when experience shows that appropriate use and quality are being achieved while assuring that providers remain viable. This might take two to three years and would depend on the variability of the population(s) being targeted. The more variability the longer the time period to full risk coverage—assuring access at high quality should be the number one goal within total revenue targets.

- d) What should be the relative size of potential payments conditioned on whether a provider is accepting full risk as compared to a shared savings model?

The goal ought to be high quality care within a reasonable global budget (a bending of the cost curve). Full risk payments without a robust measurement infrastructure in place will only result in poor care delivery. The early focus ought to be on measurement. Shared savings payments ought to be a very large percentage of the savings when there is a demonstrated commitment (or even contractual agreement) to put these dollars into the infrastructure of caring for the population served.

- e) In the case of either a capitated or a shared-savings model, what should be the maximum amount of "bonus"? Stated differently, what is the minimum Medical Loss Ratio for a provider?

Since patients are assigned to the Care Coordinator (and there are no marketing/advertising costs), and historical rates used to set the capitation rates are well below provider costs and other market-driven payments (most commercial payers pay two to three times Medicaid for similar services to physicians and ancillaries), the minimum Medical Loss Ratio should be set similar to the overall Medicaid system levels of 90+%.

- f) Who should be at risk? Is it sufficient that the coordinated care entity accepts risk, or must there be a model for sharing that risk with direct providers?

Once base rates and performance inequities are stabilized at sustainable levels, a shared model makes the most sense.

- g) How should risk adjustment be included in the model? Conversely, how should "stop loss" or "reinsurance" programs be incorporated?

This is an important balance issue. At least three types of risk adjustment should occur: 1) patients with similar resource needs and utilization patterns should be grouped together with rates set appropriate for the quality (use and outcome) desired; 2) patient populations

should be monitored and payments adjusted if underlying population characteristics change (if the population intended is not the population seen); and 3) where “unpredictable” patient-(or family-)generated risk occurs and the provider can demonstrate it, “stop loss” should be offered.

- h) How can the state assure that capitated rates or other risk-based payments are not used to limit appropriate care or serve as a disincentive to diagnose and treat complex (i.e. expensive) conditions?

Not easily. This is why the State needs a robust measurement system before stepping into risk based payments. Even for low complexity populations this will be difficult. Questions naturally arise: a) why did a particular patient not get a specialty appointment? Perhaps, inappropriate limitation (the patient would benefit but the costs to the at-risk organization are high and barriers are created); Perhaps, lack of access; Perhaps just good clinical judgment. For high complexity, high cost patients the need for measurement (cost, quality and patient experience) is even more important and more difficult. Ongoing comparisons with commercial population utilization and practice for “routine” populations should be sought; multiple state comparisons for complex populations should be sought and used where appropriate.

5. What structural characteristics should be required for new models of coordinated care?

The delivery system requirements/structural characteristics should be tied directly to the population being targeted; the more complex the patient needs, the more encompassing the provider resources required. And the payment structures should follow the degree to which delivery system complexity is known---the more predictable the care, the more risk based the payments can be, the less predictable (complex?) the care needs, the less risk based should the payments be with more pay-for-performance and shared savings type payments being used.

Questions for Comment

- a) Should Medicaid lead or follow the market? Should we contract only with entities with operational, proven models or should we be willing to be an entity’s first or first significant client?

Medicaid covers the largest single population in Illinois. By definition, they must be a leader since they are the only entity that can balance vulnerable population needs and state economic interests. All other payers not only do not have this market penetration but also do not represent all citizens’ interests like the State does. Nevertheless, securing appropriate service for vulnerable patients should be DHFS’s first priority. Problems in securing primary and specialty and ambulatory care services already exist for this vulnerable and important population. In addition, the social issues and needs for families with limited incomes

frequently exacerbate their capabilities to seek and receive needed care.

- b) What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements? How should the determination of “minimal financial base” be different for one and two-sided risk arrangements? Should Department of Insurance certification be required?

We do not know the precise answers here but do not believe adding administrative burdens to entities seeking to serve (or continuing to serve) this population is advisable. DHFS has always needed to balance the needs of patients with the need for a sustainable delivery system without DOI intervention. Nevertheless, when non-provider entities are added, they must have appropriate resources to assure they will be able to meet and sustain the service delivery requirements that DHFS and the citizens are expecting for this vulnerable population.

- c) Should there be a minimum number of enrollees required in an entity for it to be financially stable and worth the administrative resources necessary to accommodate it and monitor it? Should that amount differ by types of client? Can it be different for entities taking one-sided as opposed to two-sided risk?

Financial and administrative risk is directly tied to size. A thoughtful evaluation of the amount of control and risk assumed should be tied to the complexity and uncertainty of the care and resources required.

- d) What primary care or access to specialty care should be required? How extensive should be the network of providers to be able to offer access to a full range of care?

There must be a coordinated and adequate set of provider resources to meet the expected needs of the targeted population--the more complex the population, the broader and firmer the provider commitments to meeting those needs.

- e) Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

Absolutely, subject to appropriate performance standards, monitoring, risk assumption and network performance.

6. What should be the requirements for client assignment?

Questions for Comment

- a) The Medicaid reform law requires that clients have choices of plans, as do federal regulations. Would it make sense to limit the choices of clients by underlying medical conditions? (For instance, can all clients with specified behavioral health issues be required to choose among a different set of providers than clients not so identified?) Is this practical?

Only makes sense if the segmentation of the population can be done with limited ambiguity and the needs of the population are likely to go unmet by some providers (or that there can only be limited set of providers in order to achieve scale. A likely candidate for such segmentation is children dependent on medical technology and/or home nursing services.

- b) How much should the Department stratify choice areas by geography? Considered alternatively, would a provider need to have network coverage throughout a major area, such as Chicago? Or could a coordinated care entity limit its offerings to a particular neighborhood?

Adequate size to measure cost and quality

- c) Can entities limit the eligible population they serve, and how narrowly can they limit their population? (Can providers, for instance, limit themselves to AABD or TANF populations, or even more narrowly, such as children with complex medical needs or individuals with serious mental illness)?

We believe delivering high quality patient care should come first. Yes, if specific population focused care is the best approach to care coordination.

- d) On what basis should assignment of clients who have not self-assigned be made in the first year?

Auto-assignment should be made by geography and a match of the patient's likely needs with the entity's expertise and range of services. Providers should not be at-risk for auto-assigned individuals that do not engage with the medical home or the care coordination activities after efforts have been made to engage them.

- e) One approach would be to make auto-assignment to capacity in proportion to the self-assigning choices. Another approach would be to allow providers to bid on slots, with lower rates getting a larger proportion of the auto-assignees. What are the strengths and weaknesses of these approaches? Are there other approaches?

Matching the proportion of self-assignment would up the stakes for getting patients to sign up for an entity. This is probably not the best activity to incentivize. Bidding on slots and assigning more

to low bidders is a losing game for patients and the State.

- f) Over time, the auto-assignment bases could change: one approach would be to make auto-assignment in relation to outcomes. Cost could also be a factor. How long a period should be allowed before switching to a more experienced-based formula?

A thoughtful assignment based on what is likely to be best for the patient ought to be made from the beginning. At first this may be based on matching geography and complexity. However, over time more and more auto-assignments ought to be made to high performing institutions. This should be done over the same time period as the introduction of risk (with caveats as for the previous answers: may be different time lines for different populations, with the most complex taking the longest to auto assign based on experience with initial assignments made to institutions with proven records in treating the specific populations). It is also important that the infrastructure to support these assignments (IT and informational) needs to be adequate to provide the support needed, e.g. if patients assigned to clinics then clinics must be supported; if physicians then physicians.

- g) Whether for self or auto-assignment, should there be a client lock-in period? If so, for how long? What safety mechanism should exist for clients where stringent enforcement of the lock-in would be detrimental?

There does need to be lock-in for any risk based model (or shared savings). The continuity will benefit the patient as well. Where possible family supported care should be encouraged although for complex patients a mixed model may be worthy of exploration. There needs to be an appeal process with categories of reasons. Certainly a documented change of address could be a legitimate reason for changing networks. If because of access or quality issues, then this should be tracked and counted against an entity for getting future auto assignments.

- h) If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?

Maybe population or area specific focused demonstrations would assist here.

- i) How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?

No opinion since we have no experience with this category of patient.

7. How should consumer rights and continuity of care be protected?

With children with special health care needs, it is rare that one health care organization can

provide all needed services. This is a function of the service needs of each child, availability of pediatric subspecialists, types of hospital services available (like rehabilitation), long term relationships that families have with certain providers, families' geographic locations and access to services, and the role that supportive services like early or school-based intervention plays. It requires the care coordination entity and the family to work together to develop a care plan. It should be the responsibility of the care coordinating agency to work with families to assist them and teach them to navigate the health care system and be advocates for their children. The level of responsibility for each family and the care coordinator must be individualized based on an array of factors.

The care coordinating agency should have an established process to engage families in determining how services should be delivered and the essential components to meet their needs. The exact composition of this process should be left to the care coordination agency, meeting standards established by DHFS.

Questions for Comment

- a) How do we assume continuity of care as entities come and go or change contractual status? (This issue could be particularly acute if HFS "leads" the market by allowing contracting with entities for whom Medicaid is their only coordinated care contact.)

See discussion above.

- b) Although not strictly a coordinated care issue, how can continuity of care be maintained for low income clients across Medicaid and other subsidized insurance programs--such as will be provided by the Health Benefits Exchange under the ACA? In that respect, how important to continuity is a Basic Health Plan (a provision in the ACA that allows States to create a plan for clients with incomes between Medicaid eligibility and 200% of the Federal Poverty Level)?

See discussion above.

- c) Should plans be required to offer plans in both Medicaid and the Exchange, with essentially transparent movement from one to the other if client income or circumstances change?
- d) What rights, if any, should the client have to continue a medical home relationship in changing circumstances?
- e) What mechanisms should be required to obtain client information on an ongoing basis about plan quality? What appeal rights might be necessary?

8. *What is your organization's preliminary anticipation of how it might participate in coordinated care?*

Questions for comment:

- a) How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care Networks or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't sure how your organization would participate, what would be some of the factors impacting your choice?

La Rabida has been and will continue to be committed to serving the needs of children with complex healthcare needs and their families. Nearly 90% of our patient revenues come from Medicaid; we have no other payer to rely on. A workable, predictable long term service expectation and economic relationship must be maintained between La Rabida and the Medicaid Program. For many years, we have worked to build an integrated and sustainable medical home for our patients and their families. We have used historical “block grants” (supplemental payments) to cross subsidize the building of these services. When discounted fee-for-service payments continued to decline (or were frozen), we worked with our partners to continue to provide essential, high quality care. Our recent NCQA recognition (the only such recognition for our provider type in Illinois), demonstrates how far we have come, and yet we have a long way yet to go. We will continue to need DHFS support, encouragement and patience. We are ready to assume some risk for a portion of our populations and our services. For others, it will take more time. We developed and shared with DHFS a specific care coordination proposal for children with complex healthcare needs that we remain interested in pursuing. In addition, we are working with others (notably the Medical Home Network) to coordinate services for a broader population of children. And for still other populations not ultimately covered by care coordination (whomever they might be), we will rely on an adequate and sustainable payment system that allows us to continue to care for children and their families that we serve in Chicago and surrounding areas. This will take the combined efforts of State and the provider community to effectively and sustainably meet these important needs.

- b) Do you have some model in mind that you think would work to meet the terms of the law and also work well for you and the patients you serve? If so, please share it.

We have shared some ideas directly with DHFS in past. We remain committed to them now and within these questions we have offered suggestions on how to move in the future.

- c) Is your organization considering developing a Medicare ACO? Do you see opportunities for entities like ACOs in the private market? How do you see yourself involved in either Medicare or other forms of ACOs?

La Rabida is focused on children and children with complex needs. Historically these have been covered by Medicaid because of our location and the costs associated with care of this type. We expect this combination to continue but will pursue with other payers models of service that meet the unique needs of the population we serve.

- d) If your organization is considering participating in Medicaid coordinated care in some way beyond contracting with coordinated care entities, do you think you will be ready to do so by mid-2013? If not, when?

Our specific proposals have been communicated directly to DHFS.

- e) For how many Medicaid clients could you anticipate taking coordinated care responsibility? Is there a particular group of clients for whom you believe your organization is particularly suited or for whom it has developed particular expertise?

Our specific proposals have been communicated directly to DHFS.

Specific Questions we have for DHFS: