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June 30, 2011

Julie Hamos
Director
Illinois Department of Healthcare and Family Services
201 S. Grand Avenue East
Springfield, IL, 62763-0002

Dear Director Hamos:

The Illinois Hospital Association (IHA) and its 200 member hospitals welcome the opportunity to work with the Department of Healthcare and Family Services (HFS) and other providers to develop strategies implementing care coordination programs pursuant to PA 96-1501. We share the goal of better outcomes, improved access and outstanding quality while being a good steward of public resources.

In order to honor your deadline of July 1, we are providing this initial letter and will follow up with answers to questions that you posed after receiving additional input from our membership, including from IHA's Board of Trustees next month.

These are the same kinds of questions that other very sophisticated organizations are grappling with. In the public sector, the Centers for Medicare and Medicaid Services (CMS) has been working on care coordination for many years and recently published a proposed rule to implement Accountable Care Organizations (ACOs). Despite its enormous resources, CMS has missed the mark – as is evident from widespread concern expressed from those responsible for implementation. The ACO proposal has generated thousands of pages of public comment filled with deep concerns.

Blue Cross/Blue Shield, with its sophisticated information systems and analytic capabilities, is entering into contracts with providers to provide more accountable and coordinated care. However, it has not found a care coordination model that will fit all health care providers in all communities. Developing coordinated care systems to improve the care for the Medicaid and other populations served by the state will be even more challenging.

As the Department bridges to an improved and more efficient health care system for Illinoisans who receive their care through public programs, we urge you to first work with stakeholders to develop clear goals. The discussion can then move to how those goals can best be achieved. Given the complexity of care coordination for the populations served by the state, we hope the Department will strive for an approach that contributes to the body of research being developed and considers the need for training of physicians and other team members who will be essential to implement effective care coordination. We offer the following initial thoughts:

- Build on and improve programs that are currently being used to coordinate care, such as the primary care case management model and models being tested in the private market.
- Allow for flexibility in the approach to both care coordination and financial risk that are developed. What may work in one community or for one provider will not necessarily work elsewhere.
- Consider models that target those who have chronic conditions and that include health homes in order to take advantage of an opportunity to leverage a 90% federal match. At the same time explore federal grant opportunities to offer financial assistance to high Medicaid providers who do not have the resources to invest in the infrastructure needed to better coordinate patient care.

Hospitals and health systems are the backbone of health care delivery and are essential to making care coordination effective for the state. Illinois hospitals are critical partners since other providers simply do not have sufficient infrastructure or analytic resources needed to successfully move 50% of eligible recipients into coordinated care programs. These are assets that only Illinois hospitals can bring to the table since few Illinois physicians are organized in the large physician groups that dominate in some other states.

IHA is committed to supporting the state's efforts to successfully transition to improved models of care for its patients and appreciates this opportunity to offer initial comments. Finally, we are attaching a document that reflects IHA's initial perspectives on coordinated care under the Medicaid program. This document has many ideas, some of which have been acted upon, with regard to Medicaid reform.

We thank you for this opportunity to comment and look forward to many more detailed discussions as we work together toward an effective and meaningful care coordination system in Illinois.

If you have questions in the interim or at any time, please feel free to contact me.

Sincerely,

Maryjane A. Wurth
President

Illinois Hospital Association Perspectives on Care Coordination in the Medicaid Program

Introduction

Hospitals welcome the opportunity to work with the state to reform the Medicaid program through better coordination and integration of care to improve outcomes and reduce costs. We have already made a series of recommendations to the Department of Healthcare and Family Services on ways to achieve substantial savings in the Medicaid program, such as care coordination and accountable care approaches led by hospitals. Hospitals stand ready to work to pilot and test these approaches to make sure they are workable and will lead to better outcomes and lower costs.

Many hospitals are already doing substantial work in quality improvement and the management of patients with expensive chronic diseases. For example, Sinai Health System in Chicago is applying the concept of "pre-primary care," putting low-cost resources in the community, avoiding the need for expensive emergency room visits and hospital admissions, thus reducing unnecessary utilization and costs.

Sinai's pediatric asthma intervention program sends community health workers and lay health educators into the community to provide individualized care and education to children and their families. The program has led to dramatic reductions in the frequency of symptoms, asthma emergencies, as well as fewer ER visits and hospitalizations. Cost savings from this program are about $5 to $14 for every dollar spent. That is an incredible rate of return from an approach that offers great opportunity for reducing acute-care spending in the Medicaid program and can be replicated across Chicago and the state.

We all recognize that maintaining the status quo is no longer acceptable. We not only need to transform our health care delivery system, but also address the state's continuing fiscal challenges. When people talk about transforming health care so that every patient gets "the right care in the right place at the right time," and about "bending the cost curve," those phrases sound simple enough on the surface. But they represent a highly complex challenge for all of us. Hospitals, physicians, home health and long-term care providers, insurers, policymakers, government and other key stakeholders – we must all work to sustain and strengthen the Medicaid program and the health care system in the short-term, while developing innovative approaches and reforms to transform Medicaid and health care in the long-term.

IHA and the hospital community are strongly committed to continuing their partnership with the state to support a cost-effective, efficient Medicaid program that promotes timely access to quality health care. Illinois hospitals have consistently collaborated with the State over many years to identify pragmatic and workable mechanisms to control Medicaid costs and improve care – including developing primary care case management and disease management, reducing inappropriate prescription drug utilization, and promoting medical homes for Medicaid patients. Hospitals have also partnered with the state to bring in

billions of dollars in federal funds for the Medicaid program, through the Hospital Assessment Program, which also significantly benefits non-hospital providers.

It is important to keep in mind that the Medicaid program not only ensures the health and well-being of all Illinoisans as a vital part of the state's health care system, it also provides a huge stimulus to the local and state economies. As Medicaid dollars are cycled through the health care system and the economy, they generate revenues and bring in considerable, additional non-state funding – and they support hospitals in their role as major economic engines, with hospitals creating and retaining more than 425,000 direct and indirect jobs for the state.

As you consider strategies and reforms for the Medicaid program, we urge you to "first, do no harm" to patients and the health care delivery system. We urge you to review what is working well and build on those approaches, and to test out new strategies through pilot and demonstration projects before considering their implementation on a wider scale.

The expansion of the Illinois Medicaid program, under health care reform – with 100 percent federal funding – provides an excellent opportunity for the state to address critical needs, explore new strategies and models of care, and pilot innovative approaches to deliver care – with the intent of discovering methods that provide better value and outcomes. At the same time, under the Affordable Care Act, the federal government is providing funding for pilots and demonstration projects. We urge the state to seek federal funding to test new approaches and strategies for the Medicaid program.

We respectfully offer the following comments:

Consider New Care Management Approaches

Over-utilization and avoidable utilization of health care services is as unwise as it is costly. The challenge for the Medicaid program, and any other health care payment system, is to incentivize the delivery of the right care at the right time in the right place. The existing volume-based payment incentives may not always promote such care and new, value-based approaches need to be tested and workable solutions should be adopted.

It should be noted that IHA and the Illinois hospital community have long been engaged in the relentless pursuit to advance quality patient care and outcomes across the state. In 2010, IHA created the Quality Care Institute, a statewide center, to promote excellence in performance improvement across Illinois' delivery systems. The Institute's dynamic efforts build upon existing quality and safety initiatives, engaging our organizations in shared learning networks and applying innovative strategies for strengthening the quality of health care delivery – with the ultimate objective of becoming national leaders in quality patient care. We are pleased to report that more than 200 hospitals and health systems are actively engaged in the Institute's "Raising the Bar" campaign to substantially reduce readmissions, and hospital-acquired conditions and infections.

Care management, while not a new or revolutionary idea, is a central theme of health care reform. Its goal is to bring together primary care physicians, specialists, hospitals, long-term care and social service providers to organize care around the needs of the patient to achieve improvements in health more efficiently and effectively. Although the wisdom of care management has never been questioned, our volume-based payment systems have never adequately funded or incentivized this approach. To make care management a viable solution to inappropriate health care utilization, our payment systems need to incentivize such care. One of the most promising new payment ideas borne out of health reform is the creation of Accountable Care Organizations (ACOs), which are designed precisely to incentivize care management.

Pursue Medicaid ACO Demonstration Projects & Grants

IHA recommends that Illinois pursue the analysis and development of a multi-year, federal Medicaid waiver to bring substantial federal resources to the state to fundamentally restructure our Medicaid program toward accountable, value-based care. With these federal funds, the Illinois Medicaid program should support and fund a number of ACO pilots or demonstrations throughout Illinois to determine whether and how this care management approach can significantly improve the care of Medicaid beneficiaries and slow the rate of growth in the cost of covering this population.

To achieve meaningful results, the state will have to use these new federal monies for the up-front investment of resources required to give these pilots a realistic opportunity to succeed. Federal Medicaid waivers and grants offer a tremendous opportunity for Illinois to promote this initiative without having to fund it completely out of state revenue. The following elements would need to be included in this bold and innovative approach.

Start-up Funding:

1. **Investing in Delivery System Infrastructure Improvements.** ACOs must implement meaningful and identifiable reforms in care delivery, patient engagement, and other aspects of health care that will credibly improve health and reduce the growth in costs. The state should provide funding for the creation of an ACO provider network with an ACO management structure for administrative and care coordination support (e.g., claim adjudication; ACO provider network contracts; management of incentive payments to providers; provider relations and coordination; care and utilization management; and quality and efficiency measurement).

2. **Health Information Technology.** The State should fund health information technology for each ACO that connects all of the ACO providers and allows for proactive patient care management and the clinical tracking of patients throughout the delivery system.

ACO Elements of Success: The core elements of a successful Medicaid ACO pilot include the following:

3. **Primary Care Focus.** ACOs must be established on a strong foundation of primary care to promote preventive health care and to enhance patient wellness. Accordingly, the state must offer ACOs sufficient funding to attract primary care providers to serve in these demonstrations for primary care management of the Medicaid population that is enrolled in a participating ACO.

4. **Continuum Care Capacity.** The ACO must be able to manage the full continuum of care for all of its Medicaid beneficiaries, from primary care to end of life service.

5. **Sufficient Size in Patient Populations.** The state must assure enrollment of a sufficient number of Medicaid beneficiaries in each ACO to ensure that their quality and cost impacts can be reliably measured and evaluated.

6. **Data and Healthcare Analytics.** The state should assist the ACO in understanding the health risks of its Medicaid population and appropriately fund the analytical resources they will need to achieve the desired level of care coordination that improves quality and contains costs.

7. **Shared Savings.** Although the existing volume-based payment system may be the default approach for some services, the state should develop new ACO payments that provide incentives to avoid cost and create savings, such as medical home payments, care management fees, bundled payments, and other possibilities. The state should also offer ACOs performance bonuses for achieving measurable quality targets and reductions in overall spending growth for its Medicaid population.

8. **Provider Incentive Payments.** ACOs must offer realistic and achievable opportunities for their providers to share in the savings created from delivering higher-value care.

9. **Performance Measurement.** ACOs must participate in ongoing performance measurement that provides meaningful evidence of health and cost impacts. Results, including patient experience, clinical process and clinical outcomes, must be transparent and accessible to patients and the state.

10. **Time.** It will take each successful Medicaid ACO pilot applicant at least twelve months to establish the infrastructure and operational policies and procedures to implement the ACO-style of care. For the state to get a credible understanding of how well each of its Medicaid ACO pilots performs, it is recommended that each pilot be allowed to operate for at least three years beyond its first year start-up unless the ACO decides to withdraw from the demonstration because of financial or operational hardship.

IHA looks forward to working with the state to pursue the federal waiver and funding opportunity described above. The need to find better ways to treat our Medicaid population coupled with the possibility of doing so with federal financial assistance are compelling reasons for proceeding down this promising path. As we look ahead, we must seek to not only preserve existing federal financial support for Medicaid, but also pursue new opportunities to enhance that support. IHA stands ready to assist and work with the state in this quest.

Investigate Care Coordination Approaches Through Demos and Grants Under ACA

Care coordination – focusing not just on primary care, but the entire spectrum of a patient's health care needs – can reduce hospitalizations, lower the rate of complications from chronic conditions, and help eliminate health disparities. Structured appropriately, care coordination can improve outcomes and reduce costs. The Affordable Care Act includes a number of new demonstrations and grants focused on service delivery and payment reform. The hospital community welcomes the opportunity to work with the state and the Department of Healthcare and Family Services to assess the feasibility of various options available under the ACA. For example:

- Medicaid Integrated Care Hospitalization Demonstration Program: Up to eight states will be selected to use bundled payments to promote integration of care around hospitalization;
- Medicaid Global Payment System Demonstration: Up to five states will be selected to test paying a safety net hospital system or network using a global capitated payment model;
- Pediatric Accountable Care Organization Demonstration Project: Pediatric providers will be allowed to organize as accountable care organizations (ACOs) and share in federal and state Medicaid cost savings;
- Medicaid Emergency Psychiatric Demonstration Project: Medicaid payments will be available to institutions for mental diseases (IMDs) for adult enrollees requiring stabilization of an emergency condition;
- Medicaid Chronic Disease Incentive Payment Program: States can receive grants to test approaches that encourage behavior modification for healthy lifestyles; and
- A new program to develop and advance quality measures for adults in Medicaid. A similar initiative for children was included in the Children's Health Insurance Program Reauthorization Act (CHIPRA).

As the state explores approaches to improve coordination of care across the spectrum of providers, we urge the state to include hospitals and other stakeholders to develop the best approaches and avoid unintended consequences that could undermine the health care system. When considering new ideas, we urge the state to test, to "prove the concept," through pilots and demonstrations. Many of our hospital members are ready and willing to participate in pilots and demos as they are seeking ways to improve the coordination and integration of care for their patients.

Integrate Behavioral Health Services with Primary Medical Care

Another innovative approach the state should consider is a **new model of care that integrates and coordinates behavioral health care with primary medical care**. Such an approach would **make behavioral health services available to a wider population** – especially to single adults without children. The state would be able to obtain federal Medicaid matching funds to help pay for those services, which are currently funded with state funds only.

Over the past several years, hospitals in Illinois have been serving a large and steadily increasing number of persons with mental health and substance use illnesses – who did not qualify for Medicaid or Medicare – in their emergency departments, inpatient beds and specialty facilities. Individuals with mental illnesses often go to the hospital emergency room in crisis because treatment was not available to them sooner and in a more appropriate setting. This unnecessarily drives up health care costs.

The U.S. Surgeon General, the Institute of Medicine and the President's New Freedom Commission on Mental Health have all concluded that primary medical and specialty psychiatric care should be integrated. They note that mental illnesses are treatable diseases, and in many cases, occur concurrently with medical conditions. For example, one-fifth of persons hospitalized for cardiac conditions have depression. Persons with serious mental illnesses die at a much younger age than the general population because of untreated medical conditions.

The situation has worsened over the past few years, as Illinois' community mental health and substance abuse systems have sustained major funding cuts, depleting the availability of services in communities across the state. The expansion of the Medicaid program presents an opportunity for the state to **enhance and rebuild community-based services**, thus reducing unnecessary utilization of hospital emergency rooms and inpatient psychiatric services, and costs.

Expand the Use of Telemedicine

There is a severe shortage of psychiatrists in the state, especially in rural Illinois and especially for children. Of the state's 102 counties, 50 do not have a single psychiatrist, and 84 do not have a child psychiatrist. Access to behavioral health services in rural Illinois has always been a challenge because of the lack of psychiatrists and other mental health professionals and the resulting lack of hospital inpatient units. Behavioral health patients in rural areas must travel great distances to obtain care. The limited number of transportation options in rural communities makes it difficult for patients to get to the few treatment options that do exist. As a result, rural hospitals are treating increasing numbers of behavioral health patients in their emergency departments until transportation and appropriate beds are available.

We urge the state to support and fund the **expanded use of telemedicine for psychiatric services**. Telemedicine has been proven to be an effective tool in bringing the expertise of academic and specialty medicine, including psychiatry, to rural communities in Illinois. For example, some hospitals have begun to use telemedicine for psychiatric patients in partnership with the Southern Illinois University School of Medicine and the University of Illinois at Chicago. Funding is needed to expand the ability of other rural hospitals to obtain psychiatric services. Some hospitals also need assistance in order to obtain the equipment necessary for telemedicine.

Another innovative approach that we urge the state to consider is telemedicine consultations to improve outcomes for high-risk pregnancies in rural areas, which has been proven to be successful in Arkansas. Under the ANGELS (Antenatal & Neonatal Guidelines, Education, and Learning System) program, that state has developed a clinical telemedicine system to ensure local access to high-risk obstetrical care and pregnancy services, maternal-fetal medicine specialists, and prenatal genetic counselors. The program facilitates real-time telehealth consultation between patients, their local physicians and medical center specialists through a statewide telemedicine network. ANGELS significantly reduced Arkansas' 60-day infant mortality rate in the first two years of the program.

Ensure Adequate Provider Networks

A major challenge for the state in expanding the Medicaid program is ensuring an adequate network of health care providers, including primary care and specialty providers. Coverage is not access to health care if there are not enough providers to meet the new and increased needs of a significantly larger Medicaid population.

Historically, due to the Medicaid program's low reimbursement rates to providers, Medicaid beneficiaries have had great difficulties in finding providers to treat them, especially in rural and underserved areas of the state. Now, the state faces a growing shortage of physicians, especially primary care physicians.

As we noted in our October 5, 2010 testimony to the Health Care Reform Implementation Council, more than one-third of active physicians nationally are over the age of 55, and most of them will retire by 2020. Also, the results of a new physician workforce study (conducted by IHA, the Illinois State Medical Society and Northwestern University's Feinberg School of Medicine) indicate that half of all graduating medical residents and fellows trained in Illinois leave the state to practice medicine elsewhere. That is due in large part to the negative medical liability environment in Illinois. According to the study, the first to examine Illinois' supply of new physicians, if new strategies are not adopted to stem this exodus, Illinois will face an even more critical physician shortage, especially in rural areas.

The Affordable Care Act's emphasis on primary care providers to improve patient access and clinical outcomes will exacerbate the need for physicians and mid-level providers,

such as advanced practice nurses and physician assistants. While health care reform holds the promise of transforming our state's health care delivery system, it also demands new ways of thinking, collaborative efforts and action from state government on the health care workforce issue.

To meet the increased demand for primary care services, we urge the state to **eliminate barriers to allow for the expanded use of mid-level practitioners.** The state must evaluate the laws and regulations on licensure, scope of practice, and payment. Instead of individual professions "protecting their turf," we need to integrate education and practice. The state should emphasize professional competence, facilitate overlapping scopes of practice, and allow all professionals to provide services to the full extent of their knowledge, training, experience and skills. This will require cooperation and alignment among various state agencies involved in various aspects of regulating health care licensing, education, facilities and reimbursement so that the state is working systematically to eliminate any barriers to health care workforce development and deployment.

Explore Payment Reforms to Improve Quality and Outcomes

We applaud the Department of Healthcare and Family Services for its efforts to transform itself from an agency that "simply pays bills for services after [its] clients get sick – to being a proactive agency that focuses on helping to keep people healthy." We note that the Department already offers **bonus payments to primary care providers for high performance** in *Illinois Health Connect* medical homes. In the 2010 General Assembly session, IHA supported legislation (SB3743/PA96-1130) that enhances payments to long-term acute care hospitals that choose to participate and meet certain quality standards.

The hospital community looks forward to continue working with the Department to consider and **test incentives for cost-effective, quality care, based on outcomes**. In the years to come, the Medicaid program expansion provides an opportunity to explore various payment reforms that could lead to more cost effectiveness and efficiencies, quality improvement and better outcomes. Such reforms might include the **bundling of payments** for an "episode of care" to various providers in different settings, such as the physician's office, the hospital and the nursing home, in an effort to increase patient care coordination among providers.

To ensure continuity of care among those who may move between Medicaid and private insurance provided through the Health Insurance Exchange, it will be critical for the state to **establish consistent coverage standards and policies and reasonable provider rates for Medicaid**. Benefit packages should be comprehensive and similar, under Medicaid and private insurance provided through the Exchange. If a patient needs health services, whether through Medicaid or an Exchange health plan, he/she should have similar coverage, and similar access to providers. To achieve this goal, the Medicaid provider rates will need to be comparable to the provider rates negotiated by the private plans offered on the Exchange.

As a cautionary note, given the importance of having an adequate network of providers, the state should be careful not to use Medicaid reimbursement rates, which are already low, as the floor for the rates in the Exchange. Inadequate rates would only discourage physicians from participating and result in challenges for Medicaid beneficiaries in finding primary care physicians, and even more difficulties, in finding specialists who will care for them.

We urge the state to **establish a committee of key stakeholders**, including hospitals and other providers, to **review proposed coverage standards and policies** for the Health Insurance Exchange.

Enhance Primary Care Case Management and Disease Management programs

The state has already taken some important steps in moving to integrate medical services into the Medicaid program. We commend the state and the Department of Healthcare and Family Services for establishing the Primary Care Case Management (PCCM) and Disease Management (DM) programs. The programs have shown great promise and substantial savings in their first few years of operation.

The PCCM and DM programs keep people healthier and help keep costs in check by preventing inappropriate and costly emergency room visits and hospitalizations. Each client is assigned a "medical home" where they receive regular ongoing care and have access to primary care doctors who provide regular checkups and preventive care. Through extensive outreach efforts, Illinois Health Connect has more than 5,000 "medical homes," including physicians and Federal Qualified and Rural Health Centers across the state.

The disease management program provides an even more intensive and comprehensive approach to patients with chronic disease, such as coronary artery disease, asthma or depression. The program coordination includes the use of nurses and social workers to ensure that participants obtain the help they need for their health, food and housing issues to get better control of their situations and reduce the incidence of costly medical crises.

These programs are all about managing and coordinating care, making sure that people get the right care at the right time in the right place, so that they are not unnecessarily using the hospital emergency room and driving up costs. Through good PCCM and DM programs, the state is accomplishing those goals. The state should not abandon the PCCM or DM approaches.

We urge the state to **expand and refine the PCCM and DM programs to include other populations, other conditions, and other providers.** For example, the PCCM program could be enhanced to include long-term care services as part of the "medical home." It could also be expanded to include clinics, Federally Qualified Health Centers, physician groups, and Accountable Care Organizations. Through an enhanced PCCM program, the state should be able to achieve better integration of services, not just by individual physicians, but also by physician groups, clinics and hospitals, who should be included as strategic partners in this effort.

Several other states, including Arkansas, Indiana, North Carolina, Oklahoma, and Pennsylvania, have sought to enhance their basic PCCM programs with additional features. While each state uses different resources for care coordination and care management and uses different care coordination methods, common themes in their approaches include: more intensive care management and care coordination for high-need beneficiaries; improved primary care physician incentives; information sharing; and increased use of performance and quality measures. We urge the state to look at those approaches as well as other enhancements to the PCCM program, including:

- Tie per member per month payments to specific outcomes that require the physician to actively engage and provide appropriate primary care to the Medicaid beneficiary;
- Disciplines, incorporating provider risk-sharing such as reductions in per member per month payments, should be considered to encourage physicians to provide top care, including adequate hours and access to care;
- Focus on true incentives for the provider and patient to reward healthy lifestyles and ensure that primary care physicians are making only proper referrals; and
- Limit doctor shopping within the PCCM system to allow for proper care management.

We also recommend several changes in the DM program, which is currently voluntary for enrollees with chronic conditions, including:

- Participation in the existing disease management program by **all beneficiaries** who are in the high-cost category or at risk of joining the high-cost category should be pursued;
- Payment for service should be contingent on meeting performance metrics and improving health outcomes; and
- Mechanisms to tie payments to the program's vendor to savings and health outcomes should also be explored.

Rebalance long-term care services

The state should rebalance and reduce its reliance on institutional care in the Medicaid long-term care system. Individuals who are aged or living with a disability or serious mental illness should remain in the communities in which they live, with quality services provided to them on a medically practical and cost-effective basis. Specific strategies to achieve this goal might include:

- Enhancing the Community Care Program for Medicaid-eligible seniors;
- Enhancing community options for people with developmental disabilities who are living in state or privately-run institutions;
- Enhancing and expanding community-based programs for those with mental illnesses; and

- Managing admissions to ensure a short institutionalization period and facilitate rapid reintegration to a community setting.

Conclusion

IHA and the hospital community are strongly committed to its partnership with the state to not only preserve and protect the health care delivery system in the short term to ensure its sustainability, but also to transform the health care system in the long term. We look forward to continue working with the state for a cost-effective, efficient and quality Medicaid program that focuses on good outcomes for patients and collaborating on ways to develop and maintain reliable, sustainable and predictable funding sources for Medicaid and the health care system.