Illinois Department of Healthcare and Family Services
The Coordinated Care Program
Key Policy Issues
Questionnaire

Report from Crusader Community Health – Gordon Eggers, President & CEO

1. How comprehensive must coordinated care be?
   a. Do you think 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?
      i. ***Yes***
   b. Must all of these elements be required in any entity accepting a contract, or just some elements?
      i. ***Different geographic areas may have different ability to provide the entire range of coordinated care (ex: Chicago vs. downstate/very rural Illinois). Don't require all elements at the start. Add on elements once the core requirements are working, such as the PCMH, PCP's, EHR, diagnostic and treatment services and outpatient care.***
      ii. ***P4P based on Evidence Based Guidelines requires careful selection of guidelines and goals; behavioral services may be difficult for certain areas of Illinois but are very important to eventually add on.***
      iii. ***Comprehensive coordinated care is achievable for clinical entities such as CHF, COPD/asthma, diabetes…. This may markedly diminish expensive ER visits, hospitalizations and readmissions. Few FQHC's have the time, resources and encounter rate funds to achieve outstanding outcomes.***
   c. Medical Homes are generally considered the hub for coordinated care. How should the existence of a 'medical home' be operationalized?
      i. ***The PCMH must be NCQA or Joint Commission accredited, with a time mandated goal to achieve all aspects.***
   d. How explicit should requirements be about how an entity achieves coordinated care?
      i. ***Coordinated/integrated care for FQHC socioeconomic and medically complicated patients will only achieve clinical and financial outcomes if monetary resources are provided to the FQHC to provide specified care coordination, and the EHR measures are reviewed and acted upon by a focused FQHC team (to monitor/data, outreach patients for follow-up and continually work with the provider and patient). The FQHC provider does not/and cannot achieve this alone, given patient exam time constraints, the large number of extremely diverse and complicated patients, and the adherence of the patient population. The FQHC cannot typically afford such additional personnel to collate, demonstrate clinical data, diminish no-show patients, increase medication adherence, and ensure post ER/hospitalization and specialty follow-up, etc..***
      ii. ***HFS would be wise (as a cost saving measure) to help FQHC's hire care managers/coordinators, 'navigators' that link the outpatient – ER/hospital visit – specialty care and rehab needs. Perhaps this can be a per member/per month add on to the encounter rate, or a flat sum based on the volume of IPA patients, or a sum based on the volume of chronic disease patients who need focused management (i.e.. diabetic, CHF, COPD, cancer…..). Let the FQHC decide how to best coordinate the care, as many different patient care scenarios exist.***
      iii.

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?
    i. ***The ability to receive pharmaceuticals is obviously important. Generics are more and more clinically acceptable, however specific trade name medications give improved outcomes with diminished need for specialty referrals and potential admissions. (ex: proton pump inhibitors for gastric problems, and certain psychotropic's…)***
f. What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?
    i. ***This is difficult, especially for specialists and hospital systems. Incenting integrated/coordinated care will help, coupled with P4P.***

2. <u>What should be appropriate measures for healthcare outcomes and evidence-based practices</u>?
a. What are the most important quality measures that should be considered?
    i. ***Seek consultant help in this regard, perhaps by the Intermountain Healthcare System. FQHC's need a steady, time-honored list of measures. Presently, new ones have shown up from HRSA/BPHC, in addition to Medicare and HFS measures.***
b. Is there one set of measures for different kinds of clients?
    i. ***Different measures are appropriate for different groups. Don't overload the list at the start. The healthcare systems (whether they be FQHC or hospital based) need more time and patience to 'mature' their EHR capabilities (to collect and disseminate data; to notify the provider team if a patient needs a preventive exam, etc…)***
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?
    i. ***Low socioeconomic/FQHC patients are far more difficult to achieve clinical outcomes, versus the private sector (with improved education, English fluency, private insurance, a high show rate, better prescription adherence etc… Assign a 'FQHC RVU' to give a fair risk adjustment.***.
d. - e
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?
    i. ***Seek outside consultant help from an organization that has already accomplished this. If measures are chosen, think upstream and <u>add the resources necessary to achieve them and their financial goals</u> (i.e. give a dollar to save ten dollars…)***
f. - g
How can the Department most effectively work with other payors to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?
    i. ***Convene a clinical group to carefully select yearly measures. Once each measure (or most) have their clinical and financial goals achieved, add another one (but not many). The goal is to achieve both types of goals.***

3. <u>To what extent should electronic information capabilities be required?</u>
a. What type of communication related to the clinic care of a Medicaid client should be required among providers until electronic medical records and health exchanges become ubiquitous?
    i. ***A functional EHR is a key component, especially if the FQHC has a large patient population. Hand tabulation is inadequate except for small subsets. HFS can use billing data for certain measures.***
b. Should the Department offer bonuses for investments in EHR systems, above the substantial incentives from ARRA?

i. ***If feasible. Consider bonuses if the EHR is being utilized in an advanced manner (i.e. it is able to collate and differentiate lists of patients with specific clinical outcomes that need improvement; or if it can notify the provider at the time of service if the patient needs a clinical measure worked on or accomplished, etc..)***

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?
   i. ***Keep the base rate. Add P4P incentives. Eventually, with a fully integrated care program you will want a electronic health exchange – 'cloud', to connect the PCMH – hospital- specialists. Incent this goal.***
d. On what time frame should we expect all practices to be electronically enabled?
   i. ***Meaningful Use may be sufficient. Improved outcomes will come about after the EHR is fully operational. FQHC's will actively seek this goal. It is more difficult than many expect.***

4. <u>What are the risk-based payment arrangements that should be included in care coordination?</u>
   a. How much risk should be necessary to qualify as risk-based?
      i. ***Unsure***
   b. Could 'risk-based arrangements' include models with only up-side risk, such as pay-for-performance or a shared savings model?
      i. ***P4P and shared savings both have pros and cons. Be cautious about how you incent. Don't emphasize 'bad performance' at the start. There are too many variables that must be in play to create a good outcome.***
   c. If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?
      i. ***After years of finding out what models work***
   d. – h
      i. ***To be defined***.

5. <u>What structural characteristics should be required for new models of coordinated care?</u>
   a. Should Medicaid lead or follow the market?
      i. ***Be open to new providers and new models to learn from. Seek input from the Innovation program at CMS.***
   b. What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements?
      i. ***FQHC's need the encounter rate to survive, given the range of services we already provide that don't have renumeration.***
   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?
      i. ***HFS may need enough enrollees at the FQHC to incent sufficient monetary resources to add care management staff and IT.***
   d. What primary care or access to specialty care should be required?
      i. ***Definitely need a PCP network. Access to specialty care is typically problematic. <u>Incent the EHR and care coordination, and good outcomes will follow.</u>***
   e. Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or other side difficult clients?

i. ***Per member/per month money specified for such expensive/high risk patient care (for coordinators or focused specialty clinic's requiring a longer visit with on-hand specialists. For example, a new and complex patient or a diabetic patient needing optometry, podiatry and an endocrinology visit).***

6. What should be the requirements for client assignment?
   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?
      i. ***If the Medicaid patient can easily move from PCP to new PCP, it will be difficult to achieve benchmark standards. It is important to understand that 'cherry picking is very rare in FQHC's. Instead, the problem is when the patients' clinical condition is beyond the training of the PCP, such as with a behavior health, orthopedic-surgical-specialty care need. This is amplified when the patient cannot access specialty care and the PCP practices at the edge of his or her training.***
   b. How much should the Dept stratify choice areas by geography?
      i. ***A large network of coverage would be nice, but not always practical or feasible. You should be able to stratify by geography. Try different models in different areas.***
   c. Can entities limit the eligible population they serve, and how narrowly can they limit their population?
      i. ***Yes, some entities are excellent at specific populations and can create both positive clinical and financial outcomes.***
   d. On what basis should assignment of clients who have not self-assigned be made in the first year?
      i. ***Geographic, coupled with a list of FQHC's that offer specific services the patient may need (if this is known). For example, a PCP in a network with behavioral health care, or a PCP in a network with pediatric developmental care, etc..***
   e. Approaches: auto-assign or providers to bid on slots. What are the strengths and weaknesses of these approaches?
      i. ***See above. If possible, assign on available capacity <u>but link it to established clinical competence in specific areas that are listed on the HFS database.</u>***
   f. How long a period should be allowed before switching to a more experienced-based formula?
      i. ***Eventually, auto-assignment to FQHC's with improved outcomes for specific clinical conditions the patient is know to have (if this is possible), would 'reward' innovation, integration, and transparent measurement outcomes.***
   g. Whether for self or auto-assignment, should there be a client lock-in period?
      i. ***<u>Diminish client 'doctor shopping'. There is no substitute for a strong provider-patient relationship</u>. From that flow both improved clinic and financial outcomes related to fewer tests, less frequent ER utilization, more Rx adherence, improved appointment adherence, and fewer hospitalizations etc… Do all you can to incent this, not a shorter visit.***
   h. If the Dept sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?
      i. ***Pick FQHC's 'ready' for a demonstration project, and let them use their present patients to test the care coordination clinical and financial model.***
   i. How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?
      i. ***Unsure***

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

a. – e.

i. ***No comment, except mandate continuity between entities, hopefully using an EHR to EHR transfer of care.***

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

a. - b. How would your organization participate in coordinated care?

i. ***See the last page for a draft of the model that Crusader Community Health, in Rockford, Illinois, hopes/expects to fully develop if resources are sufficient***.

c. Is your organization considering developing a Medicare ACO?

ii. ***Perhaps. The ACO model is developing. Integrated/coordinated (without the ACO title) may succeed far sooner.***

b. If your organization is considering participating in Medicaid coordinated care responsibility?

i. ***Yes***

c. For how many Medicaid clients could you anticipate taking coordinated care responsibility?

i. ***We presently care for approximately 28,000 IHC/Medicaid patients. We can see more if so assigned. We have expertise and expect to reach clinical goals for chronic disease measures, dental measures, behavioral health problems, and preventive needs (immunizations, pap/mammogram, etc….).***

Crusader Community Health, Rockford, Illinois

Coordinated/Integrated Care Program Components

Crusader's FQHC system presently offers the following components:

1. A fully developed and integrated EHR and Electronic Dental Record
2. A Medical Home with an assigned PCP for every patient
3. Exceptional clinical care for –
    a. Pediatrics (16,670 IHC children) utilizing 5 pediatricians and mid-level providers
    b. Women's Health Services (with 1000-1100 deliveries; via 7,140 adult female patients, utilizing 4 OB, Family Medicine physicians and mid-wives, and Maternal Fetal Medicine, and focused on early entry to care) Our deliveries account for 26% of Winnebago County.
    c. Adult Medicine (8,439 IPA patients; focused on chronic disease management).
        i. Specialty HIV services; specialty Homeless services
    d. On-site (to improve access, adherence, and outcomes) specialty care of neuro, medical pain management, optometry and podiatry.
    e. On-site health education with touch screen computer educational booths
    f. On-site outreach for WHS
    g. The most modern dental care system available in the United States, including an electronic dental health record, digital imaging, halogen lighting, and flat screen individual monitors in each operatory showing Pixar animation educational films to children (approx. 6,600 seen per year). We are focused on children and patients who have chronic diseases or are homeless. We have a Pediatric dental coordinator to integrate family medicine and oral health.
4. A 340B and Pharmacy Assistance Program
5. Hospital admission by physician hospitalists for adult medicine and pediatrics. Our provider staff admit all OB patients. Additionally, we are linked to the hospitals for discharge continuity.
6. Our 'Division of Clinical Quality' offers clinical focused education, respiratory therapy testing, certified diabetic educators, PharmD utilization for medication management, and a Coumadin Clinic.
7. An 'upstream' emphasis on preventive care, utilizing proactive computer pop-up screens; a dental and pediatric care coordinator.
8. We are presently implementing a benchmark Behavioral Health Program, utilizing on site real time integration of the PCP and trained MSW's from the local Mental Health entity; psychiatric med-management availability; bidirectional referral of medical and behavioral patients, and a PCP seeing severely disturbed psychiatric patients at the local BH organization. We also offer group sessions.
9. A 'Gateway Clinic' where new adult patients with chronic diseases are initially evaluated during a comprehensive (larger) appointment, whereby they have a physical exam, get lab and medication management, get their EHR squared away and finally get a referral to the most appropriate PCP.

With additional resources we want to implement and test a model that we strongly believe will be cost effective and clinically strong.

The components will include:

- ER diversion of low activity patients, back to our less expensive, high quality and assigned PCP system.
- "Patient Care Coordinator' (care and case management) and "Navigators' (lay and mid-level provider)
- Additional contracted on-site ENT and orthopedics, as these specialties are difficult to access and the deferral of care by patients creates additional morbidity and far higher cost to HFS.
- An IT 'cloud', linking our EHR to area hospitals and specialists. We are presently at work on this.
- More providers, to increase access to primary care and diminish ER utilization/costs.
- Specialty clinics on-site for diabetes, congestive heart failure, and COPD, focused on high risk/high utilization patients.

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www.crusaderhealth.org