MEDICAL HOME NETWORK

Building Partnerships for Better Health

Response to DHFS RFI for Comments on Care Coordination
June 30, 2011

On behalf of Medical Home Network, we want to thank the Illinois Department of Health and Family Services for its efforts to drive enhanced care coordination in the Safety Net. We believe that well thought out policy regarding care coordination has the potential to transform the delivery system from the current fragmented, inefficient, fee-for-service model to one that can reduce costs, improve quality of outcomes, and improve the health of vulnerable populations in Illinois.

Driving our recommendations are four central goals that we strongly encourage DHFS to prioritize as they move forward with coordinated care programs. At their foundations, these entities should strive to improve quality in health care outcomes, while simultaneously bending the projected curve in health care costs. Then, a significant portion of the savings should be sewn back into efforts to further improve quality outcomes and cost efficiencies. Additionally, this program must seek to engage both providers and patients, gaining meaningful participation. DHFS should attract new Medicaid-willing providers, as well as change provider's traditional dependence on high-volume, low-impact, poorly reimbursed services. Likewise, they should shift patient behavior and perceptions by encouraging broad acceptance among the patient population and encouraging patient willingness to actively engage the healthcare system.

How comprehensive must coordinated care be?

An entity should include arrangements between not only hospitals, primary care, and specialists, but also pharmacy, mental health, diagnostics, rehab, long term care, and other ancillary providers. This arrangement will build collaborations that can collectively manage the continuum of care and cooperate in a meaningful way. Due to the significant unknowns in coordinated care models, however, it may be appropriate to limit the initial number of coordinated care entities. These pilot regulations should provide flexibility for multiple levels of coordinated care in order to determine what works and what does not.

To reach truly value-driven coordinated care, incremental changes and interim coordination arrangements may be necessary to allow the co-evolution of organizational structure and payment arrangements. Defining guidelines for coordinated care entities should therefore take into account the necessity for transitional systems as steps to reach the ideal goal.

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

The evidence-based and tested measures endorsed by PQRS and NQF-endorsed measures can provide a strong foundation to promote practices that meet the triple aim of healthcare reform. The measures should include not only the typical HEDIS measures, but also those that measure the appropriate utilization of medical services in the appropriate settings so that under-utilization can be detected and short-term and long-term savings can be achieved. A coordinated care program ought to measure quality along the continuum, focusing on outcomes, and in particular, on high-cost and high-volume chronic disease states. Clinical performance and outcomes measures should be standardized for a population.

The number of measures should be small initially to allow entities to focus and develop competence; they can then be expanded on a yearly basis. The core set ought to include measures beyond the inpatient setting, including post-discharge place-of-service information. Similarly, DHFS should encourage and reward models with a focus on social attributes that improve health outcomes.

We also encourage DHFS to reward improved outcomes by incentivizing reductions in potentially preventable events, as these events harm patients, raise costs, and have been tied to impressive-short term savings when incentivized in public sector demonstration projects.

To what extent should electronic information capabilities be required?

Entities will need the capability to share information across participating entities, and due to the high initial infrastructure costs, DHFS should support technology that can connect disparate providers. As a starting point, health information technology should aggregate patient information from multiple sources to provide pertinent patient history at any point of care. It should serve as an invaluable tool for care-coordination, enable bi-lateral communication between disparate providers across the continuum of care, and organize the management of value-based reimbursement strategies.

That being said, while we all agree that electronic information capabilities are ultimately essential, the reality of the current capability of current Medicaid providers and the speed that they will be able to achieve this capability must be taken into consideration; DHFS must be prudent regarding excluding providers that do not meet the deadline requirements.

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

DHFS should offer a shared savings option, a global cap and other reimbursement mechanics that reward coordinated care. A global cap would offer the opportunity for provider groups to assume risk and be creative in achieving health outcomes through efforts such as patient engagement and preventive care. A shared-savings option would allow a transition to support the common efforts and interests of all provider types (e.g. Integrated Delivery Network) to build a focus on care coordination and population management and prepare them for the risk based environment. Shared savings should eventually migrate to risk as expertise and financial reserves are created. Providers and entities that

perform poorly can be removed from the program to give them significant deterrent without down-side risk. DHFS ought to advance part of the start-up costs for provider-driven networks to be paid back through shared savings, in particular.

Risk adjustment should take into account regional differences in cost of care and patient population risk, and should develop patient specific risk stratification similar to Medicare's RAP system in order to reward good management of chronically ill patients rather than offering incentives to avoid responsibility for such patients. These arrangements should avoid transferring risk to non-provider entities.

Incentives should be aligned across all groups within the care continuum to promote efforts to restructure delivery systems and improve quality of outcomes while lowering costs. To have this effect, pay-for-performance or pay-for-outcomes incentives must be substantial and meaningful to incent the initial investment required. However, incentives should reward improvement separately from exemplary performance in order to keep from improperly favoring historically inefficient providers. Access to shared savings or unspent capitation payments should be tied to achievement of reasonable care benchmarks.

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

Structurally, coordinated care models can take on many forms and should not be restricted to MCOs. Instead, DHFS should allow and promote provider driven models built on the concept of medical delivery and management of patient care. With a coordinated care approach by building collaboration amongst providers in our community, reduction in costs will be a result of integrated care, especially with those patients most at need (high risk population), and not the aversion of that risk. To eliminate the aversion to managing these sicker patients however, the model needs to offer either some form of stop loss protection against catastrophic cases or provide reimbursement appropriate for that risk. Although we envision providers as leaders in these entities, details of the governance structure can be worked out by each entity.

Additionally, it is worthwhile to note that a Medicaid care coordination model based on the Medicare Shared Savings Program would not be sustainable within the safety-net population, and would warrant rethinking many of the underlying provisions of the Medicare ACO rule. For example, where Medicare ACO would assign individual beneficiaries, a Medicaid care coordination model would necessitate a population-based, multi-hospital, community-wide approach due to the often highly mobile nature of the patients and their tendency to move from hospital to hospital. Furthermore, compared to the focus of Medicare ACOs to reduce excessive use of specialty care and expensive procedures, the focus of Medicaid is on addressing and providing demonstrable solutions regarding inadequate access to primary care and poor coordination of care.

Lastly, for reimbursement structure, DHFS should extend expectations for return on investment from a three-year program akin to the proposed Medicare ACO pilot to a five-year Medicaid demonstration program in order for Medicaid providers to establish the necessary IT and personnel infrastructure and

achieve budget neutrality. To encourage hospital participation, alternative or supplemental funding could be used as transitional sources to cushion excessive reductions in safety-net hospital reimbursements. These funding sources would have to be retooled in a transparent and accountable way.

What should be the requirements for client assignment?

Clients should initially be allowed to choose among the various models of coordinated care in their geographic area. Those who do not choose should first be attributed to the predominant primary care provider they have seen historically and then assigned to the coordinated care model that this PCP prefers. Clients should be allowed to change that assignment through a similar selection process to that of the Medicare Advantage program. This is essential to actualizing the Medical Home as a consistent site of care and the hub of the greater care coordination spectrum.

Prospective attribution and advance knowledge of assignment methodology will be important for entities to engage in population management to achieve the desired aims. Likewise, communication should be allowed between coordinated care entities and assigned patients.

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

Medical Home Network, from its conception, has sought to create a comprehensive, coordinated continuum of care to provide better care, better health, and a lower cost for the Safety Net population of Chicago. By establishing partnerships between the Illinois Department of Health and Family Services, six hospital groups, affiliated clinics, six primary care clinic networks, and high-volume private doctors, MHN has laid the groundwork for the organizational innovation that will be necessary to achieve these goals. New, currently untested models will be required to transform the delivery system. MHN and participating entities are working to serve as a proof-of-concept for the many components of these models to build the capacity to accept risk, pursue the goals of the triple aim, and share the translational earnings.

At the end of the day, system-wide transformation can only be obtained through the collaboration of parties dedicated to merging better-quality treatment with the care coordination of patients. This step is a building block to moving from volume to value, and it serves as an important template solution which can help mitigate future increases in cost and act as the key driver to change provider behavior. MHN is working hard to accelerate health care improvement by translating innovative ideas into practical results that are truly meaningful to patients, and we look forward to partnering with DHFS to achieve these goals.