**Comments – State of Illinois Medicaid Coordinated Care Program Paper**

**1. How comprehensive must coordinated care be?**

The Illinois Medicaid Coordinated Care Program must be a holistic model that includes both health care and support services. The importance of this is emphasized in the federal health care reform program that focuses on adequate links between health care and support services. Non medical home and community based services play a key role in keeping individuals more independent and do so at lower costs than medical services or residential facilities. For example, CJE's in-home services program funded via the Illinois Department on Aging allows nursing-home eligible older adults to remain independent in the community for an average of 2.7 years at an average cost of $8,000/year which is less than 25% of the annual cost of $36,500 to support an individual in a skilled nursing facility through the State's Medicaid program**.**

In order to provide the necessary holistic care, each enrollee should have an assigned care coordinator and these coordinators must have manageable caseloads. HFS should assist providers by negotiating large scale contracts to lower costs for pharmaceuticals, durable medical equipment, personal care supplies, telehealth monitoring devices and other types of assistive technology.

The largest challenge to comprehensive coordinated care is the need for adequate reimbursement to providers. HFS must establish reasonable rates that incent providers to achieve realistic outcomes. A full PACE program has never been established in Illinois, largely because the State's low Medicaid reimbursement rate made it impossible for providers to manage costs while still meeting outcomes. The Coordinated Care Program will face the same challenges if this issue is not addressed.

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

In order to assure appropriate health outcomes and evidence-based practices they must be geared to two types of client services:

A) Basic care-taking: Wherein a service is provided but change in intrinsic health or ability on the part of the client is not the foremost consideration. These would include, in some instances, home assistance to seniors or services for the disabled, where the underlying condition of the consumer may make it extremely difficult or impossible to achieve certain markedly discernable changes in status. Specific quality benchmarks can and should be developed in these instances that rely on other discernable hallmarks, such as recognized best practices in care-giving.

B) Services where a successful outcome requires behavioral change or accomplishment of an outcome by the client. These might include mental health treatment, substance abuse treatment, rehabilitation, fall risk, etc. In these instances, a client outcome, rather than the act of providing the service, is the goal. In some instances, maintenance of baseline functioning must be recognized as a positive outcome, e.g. no emergency room visits.

Provider payments need to be sufficient to cover costs but need to be tied to accomplishment of outcomes. In some instances, those outcomes may be substantially within the control of the service provider. In other instances, achievement of the outcome may require quality service provision by multiple providers. In the latter instance, payment incentive mechanisms must be developed that incent providers to work together, but that reward quality provided by individual service providers. In all cases, consumer characteristics and service mix must be taken into consideration for provider compensation such that clients requiring more complex or more volume of services are compensated for those costs.

**3. To what extent should electronic information capabilities be required? (EHR)**
EHR will play a key role in care coordination and successful outcomes, especially in the case of multiple providers. However, the State should be the driver to secure EHR funding, not the individual provider. It is difficult to suggest an implementation timeframe as the availability of EHR and the required expertise will vary throughout the State. If incentives are given for EHR implementation, but as stated, this will mean less reimbursement elsewhere, HFS will need to carefully consider whether the EHR lowers costs sufficiently so that the provider will still have the adequate reimbursement required to deliver the appropriate outcomes.

**4. What are the risk-based payment arrangements that should be included in care coordination?**
Whether a shared risk or shared savings model is used, the care coordinator who is making the majority of the care decisions and managing resources, should also share in the financial risk and rewards with the providers. Just as providers will be held to defined outcomes measures, care coordinators should also be held accountable to predetermined outcomes.

Better coordinated care has the potential to reduce overall program costs but there is also concern that costs will simply be reduced through restricted access to services without significant benefit to clients. Requiring appropriate outcomes will partially address this issue. The Medicaid Coordinated Care Program will require close monitoring to insure the appropriate balance between care coordination and the proper utilization of services. In addition, care coordination may place even more financial risk on the provider with respect to clients with less predictable and more complex service needs. This needs to be taken into account as reimbursement rates are calculated.

**5. What structural characteristics should be required for new models of coordinated care?**
Accommodation should be made for those entities providing coordinated care to more complex, difficult clients in need of more expensive services. The reimbursement rate structure should be tied to client risk assessment. The provider must be able to offer an extensive range of services, including non-medical services and social supports. This is especially true for high need populations, such as frail older adults

**6. What should be the requirements for client assignment?**
Auto-assignment based on proportion of self assigning is the recommended approach. Assignment by certain medical conditions is not favored unless incentives are given to those providers handling the more costly conditions. Do not favor a client lock-in period.

Self assignment raises concerns about a possible rise in disreputable marketing practices, leading consumers to choose certain providers for all the wrong reasons, as seen today in the home health and home care industries. In order to combat this HFS needs to educate the consumers prior to provider choice, providing guidelines as to what to look for and what questions to ask. Given the diversity of Illinois' population this education would have to be provided with sensitivity to cultural and educational backgrounds.

**7. How should consumer rights and continuity of care be protected?**
In order to insure continuity of care, regardless of a change in a consumer's circumstances, the consumer should be able to keep their plan of choice. This would necessitate providers offering plans through both Medicaid and the Health Benefits Exchange. The challenge to HFS will be how to incent the providers to offer both types of programs.

**8. What is your organization's preliminary anticipation of how it might participate in coordinated care?**
CJE has a long history of coordinated community care services through its Managed Community Care Program (MCCP) funded through the Illinois Department on Aging. We anticipate continuing coordinated community services and expanding to include linkage to medical services. We would be interested in providing these both at a primary and sub-contractor level.

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