June 30, 2011

SEIU HCII represents 85,000 home care, nursing home, hospital, and child care workers throughout the state of Illinois. As care coordination works to ensure that consumers have more access to the healthcare system outside of the emergency room, our workers will be at the forefront of providing high quality care. SEIU HCII is committed to working with the State and other stakeholders to realize an optimally performing Medicaid system that respects consumers' access to care, workers' rights, providers' needs, as well as public budget realities.

SEIU HCII believes that coordinated care offers great promise to Medicaid consumers, but also significant risk that cost "efficiencies" will be realized through reduced access to care or unsustainably low reimbursements for services, especially for frontline, direct-care services. The legislative mandate for coordinated care presents an opportunity for fundamental system transformation, and the Department must insure that that transformation is a genuinely systemic change and not a superficial shuffling of the parts within the current fragmented health delivery system. Cost saving from coordinated care must come from quality improvements that keep consumers well, prevent disease and injury, reduce unnecessary and duplicative services, and establish and increase access to appropriate care settings. Without careful oversight, cost savings could instead come from an economic "race to the bottom" that only makes the system look more efficient on paper while reducing access to quality care and exacerbating the disparities in healthcare and economic opportunity for hundreds of thousands of Illinoisans. The Department can prevent this by including provisions to:

- protect consumers from manipulation, fraud, neglect, and abuse,
- protect safety net providers from losing more necessary resources to provide care to vulnerable populations,
- protect workers from becoming scapegoats and targets for cost control measures that do nothing to enhance care coordination or quality.

Below are SEIU HCII's responses to the questions posed by HFS about coordinated care in Medicaid. We look forward to collaborating with the State to help develop a plan for a just, efficient, and fair Medicaid care coordination system that can be a model for others to follow.

1. A) SEIU believes that the HFS should respond to the mandate from the state legislature in ways that promote innovation in care coordination and broaden patient-centeredness and consumer direction in healthcare. As such, we believe that care coordination should not be limited to models of managing care through contracted managed care organizations. HFS should foster new models that would allow providers in Illinois to form their own care coordination networks, such as Accountable Care Organizations or other integrated networks, as encouraged by the ACA. Furthermore, we believe that as long as Medicaid providers are willing to cooperate with consumers and with each other to implement collaborative plans of care and share records to prevent needless duplication of services, the state should maintain a role in the health care finance and delivery system for Medicaid enrollees. As Medicaid enrollment expands in 2014, it will have the potential to influence the whole health care delivery system, and HFS should consider this opportunity to develop and spread more just and effective models for care coordination as it implements the coordinated care mandate in Medicaid. A contractor distinct from providers may not be necessary or even desirable if provider incentives can be better aligned with efficient, high quality outcomes while guiding the whole system toward a the crucial goals of prevention, wellness, and reducing health disparities.

   B) While ultimately the goal should be for consumers in a coordinated care plan to have access to any and all needed Medicaid services within the integrated system, new and innovative care coordinators will need some time to incorporate all services, particularly long term services and supports, services for individuals with developmental disabilities, and other such services where there is less institutional familiarity with care coordination. Stakeholder input throughout planning and implementation will be crucial for expanding coordinated care to these parts of the system.

   C) SEIU believes that operationalization of a “medical home” model should give the consumer maximum choice in medical homes and minimize the need for any consumer to abandon an existing primary care provider, if they have one. In particular, rules should be designed to ensure that no consumer is left with little or no choice in medical homes due to their geographic location or care needs. In general, Medicaid care coordination programs should strive to facilitate informed decisions based on available evidence and consumer preference. For medical homes, this guideline would mean that consumers should be able to keep a provider that they trust as a medical home. Quality standards based on evidence-based practices and comparative effectiveness research should be utilized, but every attempt to make sure that providers that don’t immediately meet those standards have the opportunity to implement quality improvement initiatives. In areas with health care professional shortages and for populations who are adversely affected by health disparities, it is especially important to both invest in improving the quality of existing providers who are willing to make necessary reforms, recruit new providers, and respect the social and cultural context in which consumers choice providers.

   D) Consumer care cannot be properly coordinated without direct input from the consumer, so naturally an entity must incorporate someone who has regular personal contact with the enrollee. This individual need not be an integrator employed directly by the managing entity. Indeed, many Medicaid consumers already have personal assistants and care coordinators whom they work with directly, and it is in nobody’s interest to duplicate or replace these experienced and trusted providers. Furthermore, it is in the best interest of quality care and

program integrity for care assessment and monitoring to be done by someone independent of the risk-bearing integrating entity.

E) The State should be actively engaged when opportunities exist to take advantage of the large and soon to be increasing numbers of Medicaid enrollees to achieve discounts from suppliers and manufacturers. However, it is vital that such administrative processes remain distinct from clinical decisions about prescribing medications. Within certain evidence-based parameters, but with room for flexibility to implement personalized medicine, physicians should be free to exercise their clinical judgment concerning medication utilization.

F) SEIU believes that the state should recognize that the field in which healthcare providers operate is fundamentally uneven. Therefore, before expending resources on incentives for well-funded providers, the state's duty is to ensure that participation in these entities is viable for providers serving under-served areas and populations, through, for example, assistance with EHR adoption and meaningful use. The State should take seriously the objections of providers to coordinated care proposals, and work with them to develop reforms that they can embrace. System change will require culture change from many providers, and if they do not trust the process for reform, or if the timelines and mandates are, or are perceived as, unreasonable, even the most sophisticated proposal will end in failure. Therefore, incentives for providers to join in coordinated care networks should avoid 'take-it-or-leave-it' style of penalties that deny rate increases or cut rates to providers, especially safety net providers, that may have genuine concerns about autonomy, financial viability, and patient care under a coordinated care system.

2. A) While the state is understandably focused on outcome-based quality measures, a quality measurement system should once again recognize that the field in which healthcare providers operate is fundamentally uneven. Many healthcare providers that serve poorer and more Medicaid-dependent communities, if measured today solely on health outcomes, would rate poorly compared to providers in wealthier communities, due to factors beyond their control. SEIU believes that quality metrics should not punish these "safety-net" providers or the people who rely on them by cutting them off from Medicaid dollars, further worsening healthcare disparities. Therefore, we believe that quality metrics should focus on better provider practices and demonstrated process improvements to measure the quality of care, particularly in the early stages of a care coordination program.

   SEIU strongly believes that quality care comes from a skilled, experienced, and professional frontline workforce. To that end, we hold that quality measures should ensure that the provider maintains high direct care staffing levels, and that providers under a care coordination entity should be held to their own "medical loss ratio" to ensure that the bulk of Medicaid payments are directed to direct service worker costs. Direct care workers provide frontline care, typically at low wages, but are arguably the most essential component of an effective coordinate care system. Providers should likewise be incentivized for maintaining a low rate of worker turnover and for providing paid training to direct care workers. Finally, the care coordination entity should be bound by a "responsible provider" clause that prevents Medicaid dollars from flowing to providers that violate standing law regarding the rights, dignity, and respect of the workers.

   SEIU also strongly believes that quality care means more than simply better health outcomes, but better quality of life. Therefore providers should be rated on consumer satisfaction, especially the ability for the consumer to direct their personal care, to have access to type of

care and provider of their choice, and to have their requests for changes in their plan of care responded to in a reasonable and timely fashion – even if it does not rise to the level of an "actionable" grievance. This will ensure continuous quality measurement.

B) SEIU understands that different measures of quality are valuable to different populations. The "medical model" of care that works for the chronically ill senior population is not appropriate for other populations for whom Medicaid services are less about resolving medical conditions and more about quality of life and integration into the community. However, we believe that quality standards should be specific enough to apply to all potential populations, which would be best achieved by obtaining consumer input in the design of the survey instrument, so that it addresses both the concerns of consumers in general and of specific populations (individuals with physical disabilities, with developmental disabilities, individuals with mental illness, users of durable medical equipment, etc.) Then these standards, with minimal exceptions, should be applied to all care coordination entities so that consumers are not forced to accept the one specialty network. It is quite likely that entities will specialize to some degree, proving superior in some quality standards over others, but it should be up to the consumer to determine which entity best fits his or her needs before enrollment, and to do that they will need full access to all quality data.

C) The State should exercise care to devise risk adjustment mechanisms that balance differences in the risk profile of different populations without creating multiple tiers that may inadvertently reinforce and perpetuate existing disparities.

D) SEIU believes that the number of quality measures should vary depending on both the services provided and populations that are served. They should include health outcomes and consumer satisfaction measures as well as quality of workforce measures.

E) No position

F) SEIU believes that the HFS has a fundamental duty to ensure a universal standard of quality for all Medicaid consumers. While it is perfectly reasonable to seek advice and coordination with experts in the field, this coordination must not be limited to payers, but to all stakeholders in a high quality Medicaid program – providers, consumers, workers, and the general public. If the State contemplates a move toward an all-payer care coordination system, it should ensure that the elements of such a system that are borrowed from commercial insurers are clearly consistent with the public interest by allowing for broad stakeholder review of all proposals.

G) Successful care coordination would be generally defined as eliminating unnecessary institutionalization and inpatient hospital utilization by focusing on personalized, continuous care, performed as much as possible in a home or outpatient setting. This is also what Medicaid consumers widely seek in their healthcare provision. This is why we believe there should be strong measurements of and rewards for high consumer satisfaction – the consumer *wants* coordinated care, and is best equipped to tell us if they're getting it. Encounter data such as ER usage, frequency of primary care and wellness visits, and use of HCBS instead of institutionalization can also be used to measure progress toward coordination. But all such targets should be reviewed by a broad group of stakeholders to avoid inappropriate metrics.

3. A) Communication between providers is critical to proper care coordination; however there must be guarantees for consumer privacy in order to allow consumers to be honest about their experiences and their perception of their own health and well-being.

   SEIU holds that any requirements for records sharing, particularly involving EHR, should be phased in over time and properly incentivized. Providers serving underserved communities should not be penalized for not currently having the capital to set up an EHR system or train workers in its use. Communications between different providers that can be achieved without fully ARRA-compliant EHR system should be incentivized and eventually required. Safety net hospitals and community health centers should be supported in their efforts to adopt and meaningfully use interoperable EHR systems, including support for worker training.

   B) The HIT incentives in ARRA were designed to aid hospitals in adopting and meaningfully using EHR, but any care coordination system that would include other providers (nursing homes, for example) would need to arrange access to EHR for those providers as well. Furthermore, while the ARRA incentives may be sufficient for many hospital providers, HFS should focus on access to care coordination for safety net providers which, generally, have been operating under budgetary strain for years and would need further assistance to set up and effectively utilize EHR.

   Proper workforce training will make all the difference in whether HIT can fulfill the expectations that it will improve quality and lower costs. The State should therefore develop training protocols and help safety net providers to implement them with a broad range of staff who will be interacting with HIT systems. Currently most formal training support, such as Regional Extension Center training programs, is directed at physician's offices that are perceived to have fewer resources than hospitals, but many independent community hospitals will need assistance as well, and long term care providers will need assistance if care is to be coordinated beyond primary and acute care settings. Specific efforts should be made to ensure that incumbent workers who are accustomed to paper records have access to training to allow them to master EHRs. While some new hires with distinct expertise in IT will be necessary and desirable, to the extent possible, staff with familiarity with the environment and processes of the site should be re-trained and retained.

   C) As we have stated, while the state is committed in the long-term to outcome-based performance, it would be premature to heavily incentivize these measures in the short-term due the severe health disparities between regions and populations. Therefore, we would support temporarily reducing outcome incentives to assist providers with the transition to EHR – as these incentives can be phased out over time, the outcome incentives can be phased in.

   D) We generally endorse the time frame approved by the Illinois Health Information Exchange Authority of expanding access to electronic health records to all consumers by 2014.

4. A) SEIU does not have a specific percentage answer, but we believe that the State must be cautious about how much risk providers must carry, as too much risk could adversely impact healthcare consumers. The goal should not be to shift risk, but instead to increase the quality of health care services across the healthcare continuum. We believe that there are alternative full capitation modes that would still provide for shared risk and increased quality, while also better protecting consumers and workers.

B) SEIU believes that initial implementation of the risk-based arrangements in care coordination should be phased in and should begin with up-side risk only. Potentially innovative care coordination entities and safety net providers will need time to develop the necessary reserves to accept down-side risk without compromising consumer access to care. With time, the state can transition to down-side risk by "baking it in" – retaining a basic fee-for-service model but withholding a certain percentage of the full reimbursement. The provider would only be reimbursed at 100% of fee-for-service levels after meeting the necessary performance benchmarks. This way, coordinating entities will be forced to accept some degree of risk while the maintenance of standards that Medicaid consumers rely on will be maintained. Different kinds of risk-based arrangements may be more appropriate for some integrated networks than others, and the State should remain flexible in accepting diverse models for different geographic and population needs.

C) SEIU's position is flexible on time-frames of phase-in.

D) Given that generally, only well-established entities already hold the necessary reserves to accept full risk, we are concerned that further tilting the balance by providing lower payments to entities working with other, partial risk models would serve to stifle innovation and reduce competition. The State should also exercise oversight to ensure that providers that accept more risk aren't 'cherry picking' consumers. Higher payments to those providers would inadvertently divert resources away from providers that care for vulnerable populations but may not be able to accept full risk.

E) SEIU believes that the Affordable Care Act medical loss ratio rules, including standards on what should be appropriately considered medical expenses, are the *minimum* standard to which care coordination entities should be held.

F) While some proposals for care coordination may incorporate a means to share risk with direct providers, we do not believe that HFS should stifle innovation by mandating the inclusion of such measures. We do believe that provider risk-sharing should be closely monitored and regulated to ensure that provider payment reasonably reflects the real costs of services – we do not want a "race to the bottom" between providers. There also must be total transparency on any risk sharing agreements. "Responsible provider policies" should be required to ensure that providers are not meeting cost-savings benchmarks by eroding worker standards, especially lower-income workers who could become an easy target for cost-cutting. The care coordination system should produce cost savings from quality improvements that reduce the need for expensive, risky, and avoidable medical interventions, not by encouraging reductions in worker pay and benefits. In cases where a network of providers acts as the coordinating entity as well, governance structures should be required so that all provider types have a voice in decisions about risk sharing among them.

G) While a successful care coordination plan will greatly reduce the number of expensive hospitalizations endured by Medicaid, health emergencies can never be completely eliminated. SEIU would favor providing stop-loss coverage to entities to ensure that provision of emergency care does not unduly harm the entity's continued ability to provide quality for the majority of enrollees.

H) This risk is precisely why we believe that quality incentives should go beyond the medical model and measure consumer satisfaction and quality of life in the care coordination program. Aside from enforcing the NAIC minimum medical loss ratio, specific quality metrics for complex and/or rare conditions need to be included and enforced on entities, since individual consumers with these conditions will not be numerous enough to impact the entity's aggregate quality measures used for pay for performance bonuses. Primary care and diagnostics should be insulated from the risk-accepting entity to the greatest extent possible while remaining consistent with the goals of care coordination, ideally by incorporating existing case managers, personal caregivers, and primary care providers into the system, rather than relying on care management and utilization management staff from coordinating entities. Individuals or providers that alert the HFS or other relevant agency to inappropriate care or diagnosis should be strongly protected against retaliation. Finally, the possibility that care coordination entities can "cherry-pick" desirable enrollees should be curtailed by limiting their ability to exclude expensive populations of consumers.

5. A) Illinois has had little positive experience with care management in the past, and while other states are achieving success in integrating care while preserving quality, there are challenges unique to our state in designing a system that is both equitable and cost-effective. Thus, Illinois Medicaid has little choice but to lead the market and allow new entities to propose unique and innovative solutions to care. Many models for care coordination were designed from very different perspectives than that of a state Medicaid agency, and Illinois should borrow from those models while always being sure to incorporate them into a system that serves the public interest. Some successful models may have no track record with specific populations, such as individuals with disabilities, to which the State has a responsibility that private corporations like insurance companies may not recognize. Therefore, the State should be cautious about embracing current models without considering how they would impact those populations and the distinct public role of the Medicaid program.

   B) SEIU believes that innovation is best served by allowing potential entities time to build the necessary financial base to accept a risk-based arrangement. There are many entities apart from insurance companies that have to potential to coordinate care, and the State should facilitate the development of bold new ideas for care coordination from all of them. Some certification of financial ability to accept risk short of DOI certification should be considered to allow for a broad range of potential coordinating entities, including networks of safety net providers.

   C) We believe that HFS should encourage innovation and allow new entities that might not have a large pre-existing enrollee base the opportunity to demonstrate new models of care coordination on smaller scales. Furthermore, we believe that it is important to maintain a low ratio of enrollees to case managers, so a smaller enrollee base may prove more manageable. The only necessary minimum is sufficient membership to maintain the mandated high quality standards. Any entity must be able to develop a sufficient provider network to allow for direct access to care within a reasonable distance and at ADA accessible facilities, as well as real choice in providers.

   D) SEIU believes that every Medicaid consumer, regardless of location or medical condition, should have not only access to service but real choice in care coordinating entities. Entities should be limited in their ability to exclude certain conditions, or to limit consumer access to necessary specialists or Durable Medical Equipment. All entities must contract with a Federally

Qualified Health Clinic (FQHC) to guarantee continued access to those services. Entities must contract with ADA-compliant providers, and should encourage network providers to become ADA-compliant.

E) We believe that the question should be reversed – in order to maintain real choice for consumers, the ability to handle all potential Medicaid enrollees should be an important quality measure. The entity should make special arrangements if it wishes to *exclude* an eligible population.

6. A) SEIU is opposed to limiting consumer choice. Attempting to create multiple systems of care would simply deny choice to expensive or high-risk consumers.

   B) While entities should be able to vary their geographic coverage area according to their ability, the Department should ensure that any potential enrollee has access to choice in care coordination. If necessary, providers in chronically underserved areas should be incentivized to join in, in order to prevent the creation of "healthcare deserts".

   C) In order to prevent entities from simply focusing on the most desirable enrollees, the ability to serve any and all eligible consumers in the service area should be a major quality measure for a care coordination entity. While it is likely that some entities will "specialize" in care a specific population, we believe it is best left to the consumer to self-select the best entity for his/her specific care needs, based on reported quality data.

   D) Every effort should be made to ensure active enrollment into coordination entities. If automatic enrollment is unavoidable, than priority should be given to ensuring continuity of care by auto-enrolling consumers in an entity in which their existing primary care provider, should they have one, already takes part in. In the event that the primary care provider takes part in multiple entities, or the consumer has no primary provider, claims history can be used in lieu of the designated quality metrics in the first year.

   E) SEIU is adamantly opposed to routing auto-enrollees to the lowest bidder, particularly before the Department has to opportunity to ensure that the entity can actually maintain acceptable quality for the rate cited.

   F) We believe that as data on quality metrics becomes available, then auto-assignment should be based upon the *totality* of these quality metrics, including consumer satisfaction.

   G) To best preserve choice, there should be as minimal a lock-in period as possible. In particular, auto enrollees should be given a grace period in which to immediately self-select a different entity, and a quick and reasonable appeals process should be maintained for enrollees who need to leave their existing entity immediately due to quality care deficiencies.

   H) Any demonstration project (as well as any provider network or coordinating entity) should ensure that consumers have choice of both network and provider. Without such choice, mandatory enrollment cannot be an option.

   I) SEIU believes that the Department should prioritize means of accessing Medicare money for "dual-eligible" populations who could benefit the most from the greater health communication

and access to home and community based services that would come from coordinating care. The state should seek to have Medicare dollars bundled into its total payments to care coordination entities – thus allowing it to impose the same quality metrics on Medicare provision and share in the cost savings to Medicare when those metrics are applied.

7. A) Effort must be taken to maintain vital providers in multiple care coordination entities. In particular, FQHCs should be incorporated into all entities to ensure that these services remain constant regardless of entity. In the event that a consumer's provider falls out of the coordinating entity, then the entity should allow "single-case agreements" with the original provider to give the consumer adequate time to transition.

   B) SEIU strongly encourages the state to take advantage of the Basic Health Plan provision to maintain continuity of care for low income consumers.

   C) SEIU opposes requiring all potential coordinating entities to create an Exchange plan, since this would be a barrier to entry for new entities that are prepared to offer care coordination proposals but not to develop an insurance plan for the Exchange. Rather, continuity of care can be maintained if entities without their own plan on the Exchange are required to make an agreement with a plan that does.

   D) The consumer-centered medical home is the lynchpin to successful care coordination, and this relationship should only be involuntarily terminated under extreme circumstances (e.g. fraud or abuse).

   E) In addition to robust quality measures of consumer satisfaction, including routine consumer-designed quality surveys, the Department should use de-identified claims information to monitor the ongoing quality of a plan. We strongly support a robust appeals process, including the right to appeal directly to the Department and request an independent medical review, wherein doctors outside the enrollee's coordinating entity review an enrollee's case in the event of denial of care.

8. While SEIU will not be participating directly as a care coordination entity, we do have experience to offer in the formation of an appropriate care plan. (Union Health Services is the oldest Health Management Organization in the state, with forty-six years of experience in providing quality coordinated care.) SEIU workers will also play a critical role in a successful coordinated care model. SEIU homecare workers already have direct personal contract with many Medicaid consumers, and are often the most trusted provider the consumer deals with on a regular basis. In addition to their continuing work improving the quality of life of enrollees, home care workers can, for chronically ill seniors and other populations with greater care management needs, serve as "healthcare sentinels", alerting the entity to changes in the enrollee's health status or observing previously undiagnosed co-morbidities. Entities should be incentivized to train existing workers to take on these necessary roles. Homecare workers would also serve as the consumer's best advocate in the care coordination system, ensuring that the coordination team remains centered around the consumer his/herself.