

INPUT TO HFS QUESTIONS ON COORDINATED CARE
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INSTITUTE ON PUBLIC POLICY FOR PEOPLE WITH
DISABILITIES
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Thank you for the opportunity to provide feedback on coordinated care.

- The Institute supports the use of coordinated care strategies for health care only for adults with developmental disabilities (DD). There is data available that demonstrates that coordinating acute health care provides system efficiencies and allows a focus on preventive health care.
- There is no evidence that demonstrates that converting DD community long term care to coordinated care will save any money. There is no cost savings projected. The DD population should be carved out of the pilot for community long term care.
- How will coordinated care interface with the FQHC's? FQHC's provide quality acute care and affordable access to specialty care.
- The Institute supports including state operated facilities for adults with developmental disabilities into the pilot. There are vast projected savings with this population of individuals receiving long term care.
- 40-60% of adults with DD in Illinois are considered dual eligible for Medicaid and Medicare coverage. As such they are carved out of the pilot. It makes sense to carve the entire DD population out of the pilot who are receiving community long term care supports.
- The only states looking at managed care for community long term care for the DD population as a pilot are Vermont, Arizona, Michigan and Wisconsin. Unlike Illinois, none of these states will use commercial health management organizations (HMO's) to act as the managed care organization (MCO). In Arizona and Vermont a state agency functions as the MCO. In Michigan and Wisconsin, the states purchase Medicaid long term care through risk based

contracts with local MCO's, formed largely from existing local service delivery systems.

- Managed care has failed to substantially reduce geographic inequities in access to services which promote inclusion or employment.
- Managed care imposes health oriented requirements, which do not emphasize person centered or person directed supports.
- Managed care has yet to show data that there has been improvement in the quality of life of individuals, not has it shown data on the appropriateness of supports for adults with developmental disabilities.
- The federal managed care requirements are framed around acute health care. This has no relevance when applied to community long term care supports for individuals.

1. How comprehensive must coordinated care be?

- a. Do you think that 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? Are there any alternatives you would recommend for consideration?

Coordinated care should focus on wellness and recovery for acute care and personal outcome measures for waiver funded services. The emphasis should not be on illness. When the Social Security Act was amended to include Medicaid, the intent was always to provide access to health care to low income individuals within similar options available to the general population. As the state rolls out coordinated care, they should look to options in Michigan where non-profit providers with a link to communities are offering coordinated care options, using existing community providers. The quest to scale back costs should focus on improving quality community care in a coordinated fashion, rather than shifting risk to for profit providers.

- b. Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time,

It makes sense to look to Wisconsin where they rolled out coordinated care in a particular county rather than trying to do parts of radical change statewide. The roll out of coordinated care needs to be thoughtful and coordinated. Look at the problems with the change in drug formularies that was just released. It happened over a holiday week-end. The grandfather provisions were confusing. The prior authorizations were denied for many who were eligible and people lost access to critical medications. .

- c. Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operationalized? Would existence of a medical home require NCQA certification? Would all primary care physicians be required to be in practices that meet these requirements? What requirements are essential for every practice? Presumably it would be possible to increase requirements over time. What progression would make most sense?

The concept of a medical home makes some sense. Yet, for people with DD we cannot even get DHS to fund medical care in group homes. Assessment tools are needed to drive services and supports. When models bring together primary care physicians, specialists, hospitals, nurses and other providers, the physician is the ultimate decision maker. Can we develop a system where it is truly interdisciplinary with input from other providers with a focus on quality outcomes? Should Illinois look at California's accountable care organizations? ACO's bring providers together and then reward them for taking responsibility for the quality of care for their patients while controlling costs. However, do ACO's work in long term care? Do MCO's work in waiver funded programs? The research tells us that aligning incentives and strong leadership are more important than the actual ACO organizations. Varied payment mechanisms are more important than one size fits all Medicaid rate methodologies that use capitation.

If Illinois is serious about true coordinated care then this "home" would need to coordinate the following:

- a. acute health care
- b. specialty healthcare
- c. Coordination of dental
- d. Coordination of preventative healthcare
- e. Coordination of services such as housing, TANIF and other needs in order to remain healthy

If you are suggesting an advocate/coordinator model for managing care, you can argue that this person should be located where the member has the greatest amount of contact. If the PCP is the manager of care, the PCP's office may not be the site of greatest member contact. I am assuming that the "medical home" for the patient will be the location of the person managing the member's care, depending on the model selected. For DD community provider agencies, the advocate/coordinator model makes the most sense. I would think that NCQA certification makes the most sense at the managed care contractor level. In turn, the managed care company will place requirements on providers to meet certain NCQA requirements including requirements on PCPs.

- d. How explicit should requirements be about how an entity achieves coordinated care? For instance, should the care coordination entity be required to assign an integrator or care coordinator to each enrollee?

The focus should be on flexibility that leads to wellness for acute care needs and independence for long term care supports. IN the case of person with developmental disabilities or mental health needs, they will require a care coordinator. However, everyone should have only one care coordinator, that care coordinator must be conflict free; individuals should have a choice of care coordinator. The care coordinator must be locally aware of cultural difference and support needs as well as local resources. The model to look at would include the CMS money follows the person option and or cash and counseling models.

The benefit of capitated contracts is availability of monies for whatever services that make sense to achieve the desired outcome. This flexibility is not available in the fee for service world. Grant monies that provide flexibility are good as well but will be less and less available.

- 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?

The focus should be pay for performance measures that incentivize spending on care that produces healthy quality of life outcomes. Can a statewide contract for durable medical goods provide access to innovative equipment? Local pharmacists provide flexibility, local access, individualized medication containers, last minute access to new prescriptions, etc... Can a statewide contract provide individual access to medicine in the same way that a local provider can offer or can they simply undercut the local competition? How do you preserve quality while reducing costs?

The State's buying power for items such as pharmaceuticals should be used to the fullest to reduce Medicaid costs.

- f. What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?

Currently FQHC's have some liability protections that should be explored. Could the protections that help to manage risk for FQHC's be applied to coordinated care?

Outcome measures as defined by the consumer are a good place to start. Incentivize outcome quality measures.

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

- a. What are the most important quality measures that should be considered?

The Council on Quality and Leadership has developed Personal Outcome Measures[®] (www.c-q-l.org) that could be used to measure quality for long term care options in the waiver. These outcomes are quite simple but measures what stakeholders say are important. They include:

- ❑ People are connected to natural support networks
- ❑ People have intimate relationships
- ❑ People are safe
- ❑ People have best possible health
- ❑ People exercise rights
- ❑ People are treated fairly
- ❑ People are free from abuse and neglect
- ❑ People experience continuity and security
- ❑ People decide when to share personal information
- ❑ People choose where and with whom they live
- ❑ People choose where they work
- ❑ People use their environments
- ❑ People live in integrated environments
- ❑ People interact with other members of the community
- ❑ People perform different social roles
- ❑ People choose services
- ❑ People choose personal goals
- ❑ People realize personal goals
- ❑ People participate in the life of the community
- ❑ People have friends
- ❑ People are respected

- b. Is there one set of measures that should be applied to all coordinated care or might there be different measures for different kinds of clients--for instance, children versus adults or disabled versus non-disabled?

Another option to look at is the National Core Indicator Project (NCI) which is in use in Illinois currently. More than 22 states are using these outcome measures for programs for people with disabilities.

- 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?

Standardized assessments can lead to individualized rates based upon those assessments. Human Services Research Institute (HSRI) has created a rate methodology using SIS Support Intensity scale developed by AAIDD to craft rates for people with disabilities in a number of states. One could look to Georgia for implementation strategies that worked for them. This is linked to disability services, not acute health care.

- d. 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?

See answers above.

- e. What percentage of total payment should be specifically tied to quality measures?

Years ago Illinois under HFS used a QUIP Quality Incentive Program to enhance quality in long term care (nursing homes). Right now Illinois is providing an 8- 12% profit margin to the managed care companies who are

piloting the integrated care program. IN return they manage risk. Could Illinois look to take an approach that provides quality incentive payments to drive quality and manage risk?

- f. How can the Department most effectively work with other payers to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?

Currently other state agencies have quality outcomes imbedded in their systems. For example DHS DD BQM has outcome measures as part of their current review mechanism. Adopting a statewide set of outcome measures would allow coordination of monitoring, reduce costs, and reduce the number of reviewers going into the homes of individuals receiving services.

- g. To what extent should electronic information capabilities be required?

Electronic information systems allow for trend analysis and better system review. However in these times of draconian cuts to budgets, non-profit community providers would have a difficult time finding resources to pay for a state mandated technology infrastructure. However a grant that brings the state and non-profit community providers in line with information sharing is a great goal. .

- h. What type of communication related to the clinical care of a Medicaid client should be required among providers until electronic medical records and health exchanges become ubiquitous?

A small group of thoughtful professionals can look at some of the face sheets and data bases in existence currently in Illinois to come up with an optimum data set.

The advocate/coordinator must be afforded access to any provider records as needed to manage the member's care. This will mean that providers must have paper scanning abilities for e-mailing needed information if the provider does not have an EHR.

- i. Should the Department offer bonuses for investments in EHR systems, above the substantial incentives from ARRA?

Long term care providers and waiver providers do not have access to ARRA funds for EHR systems. They were only provided to hospitals and medical practices. If you want EHR, then you will need to support waiver funded providers to access funds for such.

- j. **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? (For instance, should the amount of money available for outcome incentives be reduced to increase these incentives? Or should there be a lower base rate with specific incentives for increasing connectivity?)

- k. On what time frame should we expect all practices to be electronically enabled? How would we operationalize the requirements? Is tying them to the official "meaningful use" requirements sufficient?
 - i. It is not as simple as a timeframe. The state should be proactive to provide guidance to local providers and attract federal resources to assist with a transition to an electronic data system. Just as hospitals have been incentivized to convert to a medical records system, local community providers should receive similar support.
3. What are the risk-based payment arrangements that should be included in care coordination?
- a. How much risk should be necessary to qualify as risk-based?

At this time, the only risk should be at the managed care contractor level with the State. Sub-contractors should be offered incentives for quality outcomes and perhaps utilization management. There needs to be sufficient monies for incentives for providers to become engaged. A minimum of 10% would be a reasonable start.
 - b. Could "risk-based arrangements" include models with only up-side risk, such as pay-for-performance or a shared savings model? But if it's only up-side risk, is there any "skin in the game", without something to be lost by bad performance?
 - c. If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?
 - d. What should be the relative size of potential payments conditioned on whether a provider is accepting full risk as compared to a shared savings model?
 - e. In the case of either a capitated or a shared-savings model, what should be the maximum amount of "bonus"? Stated differently, what is the minimum Medical Loss Ratio for a provider?

There should be no cap on shared savings if the incentives for the providers have been properly designed by the managed care company. With many different types of providers, the incentives will vary by specialty and services provided.
 - f. Who should be at risk? Is it sufficient that the coordinated care entity accepts risk, or must there be a model for sharing that risk with direct providers?

It will be in the best interest of the managed care contractor to design incentives for sub-contracted providers to achieve the goals of the managed care contractor and the State. As stated previously, there should be no downside risk in order to get providers on board.
 - g. How should risk adjustment be included in the model? Conversely, how should "stop loss" or "reinsurance" programs be incorporated?

Stop loss insurance is usually used when capitation is involved for paying a provider. Since provider contracts seem to be fee for services with incentives, there is no need for stop loss insurance or reinsurance.
 - h. How can the state assure that capitated rates or other risk-based payments are not used to limit appropriate care or serve as a disincentive to diagnose and treat complex (i.e. expensive) conditions?

The outcomes measures required of the provider are an important tool in ensuring that services are not being withheld. Also, measures of the use of preventive services provided to members are routinely used in managed care cap agreements to make sure such services are not being withheld.

4. What structural characteristics should be required for new models of coordinated care?
 - a. Should Medicaid lead or follow the market? Should we contract only with entities with operational, proven models or should we be willing to be an entity's first or first significant client?

Historically Medicaid has settled for the newest providers. Often, once a medical provider established him or herself then they would traditionally stop taking any new Medicaid clients. Waiver funded providers primarily only accept Medicaid funded clients. Private pay clients are rare. The focus should be on outcomes and quality

- b. What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements? How should the determination of "minimal financial base" be different for one and two-sided risk arrangements? Should Department of Insurance certification be required?

This question seems to be focused on risk based arrangements such as capitation arrangements. If the managed care contract with the State has a revenue ceiling, then the contract is essentially capitated. The managed care company is taking the risk that total State revenue to the company will cover all care plus operating expenses and profit. In this way, the managed care company is really operating as an insurance company, minus sales and marketing. The financial base of the managed care contractor should be evaluated by the Department of Insurance. If the State is retaining some risk, this would, I assume, be considered two sided risk and would affect the amount of the minimum financial base required by the Department of Insurance.

- 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? Should that amount differ by types of client? Can it be different for entities taking one-sided as opposed to two-sided risk?

This will vary from region to region of the state. Costs of staff and physical plant costs will drive variation. The coordinated care entity should make this assessment for themselves. This should not be driven by state mandate.

- d. What primary care or access to specialty care should be required? How extensive should be the network of providers to be able to offer access to a full range of care?
- e. Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

Yes, provided that there is a choice of such specialty providers to address cost and quality concerns.

5. 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? (For instance, can all clients with specified behavioral health issues be required to choose among a different set of providers than clients not so identified?) Is this practical?

How would you make this work? Many people have multiple conditions. If you lumped all people with diabetes together, then would the people with diabetes and a heart condition have the same care coordinator or different? If someone had mental retardation and asthma, would they go to the asthma care coordinator or the MR care coordinator? Would you put all people with long term care needs together and then further sub divide them by a health condition?

- b. How much should the Department stratify choice areas by geography? Considered alternatively, would a provider need to have network coverage throughout a major area, such as Chicago? Or could a coordinated care entity limit its offerings to a particular neighborhood?

In the housing market for low income housing, one gets a housing choice voucher. It is portable from county to county and from state to state. Medicaid is really a federal program. Does it make any sense to look at issues of portability? Flexibility should be the standard for the system. Put the emphasis and incentives on the results/outcomes.

- c. Can entities limit the eligible population they serve, and how narrowly can they limit their population? (Can providers, for instance, limit themselves to AABD or TANF populations, or even more narrowly, such as children with complex medical needs or individuals with serious mental illness)?

Providers specialize in health care and social services. As long as the specialization is to target quality care and not for purposes of restrictions and discrimination, it seems reasonable.

- d. On what basis should assignment of clients who have not self-assigned be made in the first year? One approach would be to make auto-assignment to capacity in proportion to the self-assigning choices. Another approach would be to allow providers to bid on slots, with lower rates getting a larger proportion of the auto-assignees. What are the strengths and weaknesses of these approaches? Are there other approaches?

Although individual should have choice of providers, there should be some limits to restrict how often they can change primary providers. Annually seems a reasonable scope of time.

Selecting the lowest bidders does not guarantee quality services. In fact, in Wisconsin, they discontinued services with one managed care provider, because they had underbid the contract and had denied access to services to recipients. If you allow vendors to bid on people (people are not slots), the contract needs to stipulate level of care, duration and scope.

- e. Over time, the auto-assignment bases could change: one approach would be to make auto-assignment in relation to outcomes. Cost could also be a factor. How long a period should be allowed before switching to a more experienced-based formula?
 - In the first year there will be huge start up issues. It will take at least 2 years to evaluate the system change. Perhaps after the first year and then annually.
 - f. Whether for self or auto-assignment, should there be a client lock-in period? If so, for how long? What safety mechanism should exist for clients where stringent enforcement of the lock-in would be detrimental?
 - Often the lock in period is for a year. However, if there is gross neglect, there should be some mechanism for appeal.
 - g. If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?
 - In the current pilot recipients have been offered at least 2 options. There should always be at least 2 options.
 - h. How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?
 - Priority should be given to selecting care coordination entities that can coordinate individuals who are dual eligible's (Medicaid and Medicare).
6. How should consumer rights and continuity of care be protected?
- a. How do we assume continuity of care as entities come and go or change contractual status? (This issue could be particularly acute if HFS "leads" the market by allowing contracting with entities for which Medicaid is their only coordinated care contact.)
 - How does HFS handle this now? Medicaid vendor for acute care have often been a revolving door. For long term care, the providers have remained relatively stable with some change. Look to HFQC's for their experience.
 - This issue is no different than when an employer changes insurance carriers. If the member must change providers for some services under the new coverage, record transfer requests can be made from the previous provider.
 - b. Although not strictly a coordinated care issue, how can continuity of care be maintained for low income clients across Medicaid and other subsidized insurance programs--such as will be provided by the Health Benefits Exchange under the ACA? In that respect, how important to continuity is a Basic Health Plan (a provision in the ACA that allows States to create a plan for clients with incomes between Medicaid eligibility and 200% of the Federal Poverty Level)?
 - Everyone needs access to health care. Innovative options are now provided under the Comprehensive Health Care Program in Illinois (CHIPS).
 - c. Should plans be required to offer plans in both Medicaid and the Exchange, with essentially transparent movement from one to the other if client income or circumstances change?
 - That is a great idea to allow continuity of health care as people move between different employment options. It would motivate people to return

to work, as long as they no longer had to fear loss of health care due to a downturn in employment. .

- d. What rights, if any, should the client have to continue a medical home relationship in changing circumstances?

People who are low income should not lose access to a medical home unless their income goes beyond a level of poverty or they move out of state. However, some managed care and insurance companies are refusing to continue full coverage for people who are for example obese beyond a certain time frame. Well if the obesity is caused by medication for mental health that seems discriminatory. If the obesity is from lack a proper nutrition, is that because of poverty or poor eating habits? This would need to be researched thoroughly.

- e. What mechanisms should be required to obtain client information on an ongoing basis about plan quality? What appeal rights might be necessary?

It would depend who is accessing the information and for what purpose. The state should be able to access individual information for purposes of quality control. Providers could post aggregate information about outcomes, both whether the outcomes were met as well as whether the supports were in place for the individual to be successful with the outcome. However, the public should not be able to access individual client outcome data.

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

- a. How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care Networks or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't sure how your organization would participate, what would be some of the factors impacting your choice?

It might be interesting to launch a pilot with DD Community providers to launch coordinated care through the residential provider. They have 24 hour contact with the recipient. They assure total life care, access to health care, emergency response system, housing, employment, etc. Perhaps a quality incentive pilot and or a coordinated care initiative whereby cost savings within defined quality care could be retained by the contracted provider.

- b. Do you have some model in mind that you think would work to meet the terms of the law and also work well for you and the patients you serve? If so, please share it.

I urge you to look at the non-profit local community based CCE in Michigan.

- c. Is your organization considering developing a Medicare ACO? Do you see opportunities for entities like ACOs in the private market? How do you see yourself involved in either Medicare or other forms of ACOs?

The purpose of our organization is to promote best practice and good public policy. It is not part of our mission to become a provider or an ACO.

- d. If your organization is considering participating in Medicaid coordinated care in some way beyond contracting with coordinated care entities, do you think you will be ready to do so by mid-2013? If not, when?
- e. For how many Medicaid clients could you anticipate taking coordinated care responsibility? Is there a particular group of clients for whom you believe your organization is particularly suited or for whom it has developed particular expertise?

There are undoubtedly areas for comment that we have failed to include or specific questions that we omitted within the general areas we selected. Please feel free to offer comments beyond the specific questions posed, but try to make your comments as specific as possible. The purpose of this paper is to receive your input as HFS moves from the broad policy outlines provided by the law to policies necessary to implement the law in a fair and beneficial manner.

Once again, please submit comments to hfs.webmaster@illinois.gov by close of business, Friday, July 1. If you have specific questions, please pose them to the same address and we will get back to you. You should watch the Coordinated Care tab in the HFS website as we will post updates and, as relevant, clarifications and answers to broadly relevant questions as we have them prior to July