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To: [HFS.Webmaster](#)
Subject: Coordinated Care Survey response
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Attachments: [HFS Coordinated Care Questions all edits.docx](#)

Director Hamos

Attached is AID's response to your request for input on the subject of Coordinated Care. While we have answered these to the extent we understand how they may impact both primary health and long term care services for adults with disabilities, there is not sufficient information regarding the latter related to managed care nationally to comment in an informed way. We continue to question the rationale for inclusion of Developmental Disability services in the Integrated Care pilot as we see little savings that can be gained with inclusion of these specialty long term care services. We urge you to consider this as you move forward in implementation of the ICP initiative.

Thank you for the opportunity to comment.

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HFS QUESTIONS ON COORDINATED CARE

June 16, 2011

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?
 - i. Yes, although the coordination of all services for a given person need not be a primary care physician but an advocate/coordinator of care, similar in concept to a case manager which many consumers of Medicaid services have in place now.
 - b. Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time, i.
 - i. Clearly Medicaid covers a wide range of services. If the entity taking responsibility for providing the complete spectrum of services is being referenced in this question, then the primary contractor (e.g., managed care firm or Medical Home with subcontracts accessing all other needed services) must have contracts with the necessary number of provider entities to provide the full range of services. If the question is referring to sub-contracted providers, then only the elements of care provided by that sub-contractor are required in a contract.
 - 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?
 1. A Medical Home should include an advocate/coordinator model for managing care and be located/assigned where the member has the greatest amount of contact. For example, if the consumer receives services through a Community Mental Health Center, then the Center should be the Medical Home and responsible for care coordination. NCQA certification makes the most sense at the managed care contractor level. In turn, the managed care company would 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?
 - i. The greatest degree of flexibility should be the standard for operationalizing the system, instead of prescriptive measures. Rather, put the emphasis and incentives on the results/outcomes. As a system we need to incent achieving

health and independence rather than incenting for number of services rendered. This also means we need flexibility to be able to offer services that lead to wellness that may cost much less than traditional care but meet the need of the member to move toward wellness and independence. Examples of the success of these kinds of programs have been shown in CMS “money follows the person” demonstration programs. 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?
 - i. The State’s buying power for items such as pharmaceuticals should be used to the fullest to reduce Medicaid costs. Providers could take advantage of negotiated rates to reduce their internal buying costs as well.
 - ii. There are pros and cons to other kinds of umbrella coverage. For example, negotiated rates for providers – including hospitals - can drive consistency and perhaps save money but may result in fewer systems accepting members because of the lowered costs. Having state wide level of care guidelines that ensure members have access to the same services when experiencing the same illnesses can mean increased quality but without flexibility it can reduce creativity in programming that could result in better outcomes at lower costs. So it is critical that any “umbrella coverage” have enough room in it to allow for innovation that increases wellness and decreases costs and ensure rates competitive enough to ensure an acceptable network of providers who accept new clients at the covered rate.
- f. What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?
 - i. Tort law protections and other benefits now covering FQHCs could enhance recruitment of PCP and specialty physicians, and potentially other medical care providers.
 - ii. Incentivizing positive outcomes (i.e. wellness) by allowing providers to share in a pool of bonus money for meeting or exceeding goals
 - iii. Incentivizing creative approaches that decrease average cost of care while increasing positive outcomes

In the end, providers will follow the money. If the payments for services, including incentives, are not competitive with other options, providers with full schedules will opt not to participate, or will not strive for better outcomes.

- 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?
 - i. Beyond the traditional HEIDIS outcome measures for health issues, social indices such as employment and affordable, stable housing are closely

related to healthy lives and life styles. Best practices in Behavioral Health reflect first providing a stable living situation, THEN provide mental health, substance abuse and medical treatment; with supported employment being among the evidence based practices leading to mental health recovery.

- ii. Additionally, it is critical that the member be engaged in identifying their own quality health care goals and identifying if those goals are been addressed or met. If the member does not believe they are getting what they need from the provider, then they aren't.
 - iii. This also assumes that the member is receiving education and empowerment around their own wellness. If providers are not addressing this critical piece – if members do not understand their diagnosis and what they can do to help work their own wellness, then the system is failing. Without education and empowerment we keep members passive and are not encouraging the kinds of healthy behaviors necessary to reach wellness, nor are we requiring members to be active partners in care.
- 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?
- i. The National Association of Directors of State DD Agencies, “National Core Indicator Project” is highly recommended as an outcome measure system for disability service programs. Use of the Surgeon Generals 7 evidence based practices benefiting individuals with serious mental illness is highly recommended also.
- 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. We support the current situation where providers who are managing high risk populations have greater resources than those serving lower risk populations. In addition, it is important that in any new system, providers are not penalized for achieving differing results for those with more complicated illnesses and those with less complicated illnesses. Not doing so could lead to “cherry picking” only the least ill patients to be included in a practice and making it harder for those with more complicated illnesses to find providers. Finally, it is important that members with illnesses that have higher DALYS (Disability Adjusted Life Years per the World Health Organization) receive more resources than those with lower DALYS.
 - ii. Case rates based on illness and co-morbidity is one way to pay based on risk. Is this being done anywhere for outpatient conditions for DD and MH patients?
- 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?
- i. A core set of up to a dozen measures that reflect quality for any and all care. A specific set of measure of up to dozen or so for each specialty area. There have to be enough measures to have meaning and allow some kind of incentive program in place but, it is unrealistic and a burden for both the

state and the provider to have 30+ guidelines for each diagnosis, for example, or any other equally difficult set of metrics.

- e. What percentage of total payment should be specifically tied to quality measures?
 - i. Initially a small percentage-perhaps 10 - 20%, until there is sufficient data to indicate that greater percentages will yield better health care and social outcomes. The amount has to be large enough to entice providers to participate but small enough to be manageable while both providers and the system learn how to move to an incentive based system.
- 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?
 - i. Sharing information with us about the quality outcomes measures other payers currently require would be helpful. Have a standard set of quality measures all providers must meet would be helpful. Ensuring the quality standards for each specialty group are comparatively similar also makes sense – for example all specialty guidelines should include guidelines around education and empowerment of the member. Include a standard that ensures providers share information with the member's other providers also makes sense.
- g. To what extent should electronic information capabilities be required?
 - i. Research suggests that electronic records that speak to each other are critical to coordinated care. Because of the burden this places on providers within the state, support such as technical assistance and perhaps federal financial assistance would be needed to implement this strategy.
- 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?
 - i. All medical information that will be required to be shared electronically in the future should be required in whatever alternate form is available currently. 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?
 - i. EHR should be an expectation of all providers, and all should have equal access to the ARRA incentives for such investment, which is NOT the case currently; only hospitals and medical practices currently have access to the ARRA financial incentives.
- 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?)

- i. Outcome incentives are critical to reframing our system to focus on wellness and not continuing to see profit in charging for individual services provided to each patient. These should not be reduced.
 - ii. A lower base with incentives makes sense but only if the state works to help provide Technical Assistance around setting up and implementing such programs and works to access federal funds that are available for making these significant changes. The state also needs to help set standards so that systems can talk to each other.
 - 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. The state's role should be much broader than simply saying "do this by this time and we will increase your pay by this much money or penalize you in this way."
 - ii. The state must offer technical assistance, classes, written information, a guideline on how to choose software and what to expect when making this change, a how to kit for this transition and the availability of a range of approved consultants that groups can contract with, if needed. The state should also set standards for systems so that they can speak to each other. Finally the state should help access available federal funding to help offset the cost of implementing these programs.
- 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?
 - i. 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?
 - i. Incentives rather than punishers are most effective in securing desired results. Poor performers could be replaced with better performer- assuming all concur that the performance measures used are realistic and objective. Because access to providers is difficult for many members – with fewer providers being willing to offer care to our population, it seems "risky" to eliminate providers or punish them for not meeting desired outcomes. A better approach seems to both incent adherence to things we know do work, incent positive outcomes and provide additional training to underachievers. In the end, providers that cannot achieve acceptable outcomes must be removed. If reasonable incentives don't motivate the

- provider and poor performance continues, give the business to the better performers.
- c. If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?
 - i. See above responses. Not a fan 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?
 - i. See above responses.
 - 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?
 - i. 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?
 - i. 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?
 - i. 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?
 - i. 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?
 - i. For the system to change from rewarding payment for numbers of services offered to rewarding wellness and outcomes, we need Medicaid to lead the market and allow for innovation.
 - 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?

- i. 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?
 - i. Who are they talking about, the managed care contractor or provider sub-contractors? A coordinated care entity will have a better sense of what is economically viable for them in terms of numbers served. It does not seem like something we should mandate but that the CCE should chose for themselves based on their own economic models.
 - 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?
 - i. Networks need to be broad enough to offer consumers a choice of providers including specialty care. Availability of providers must be in reasonable proximity to the members. Members cannot be expected to travel to downtown Chicago for routine services. The more esoteric the service, the greater the travel distance that may be required of the member.
 - e. Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?
 - i. Yes, provided that there is a choice of such specialty providers to address cost and quality concerns, and travel distance to access services is reasonable.
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?
 - i. While the idea is interesting it is not clear that the implementation would be either practical or helpful. For example, are we sure most CCEs are able or willing to track or share outcomes by specific medical conditions? If so are we sure CCEs would be willing to contract around this kind of complexity? For example, it may be simple to pull data about the success of treating diabetes, but what if the diabetes is complicated with a mental illness and heart disease? Which conditions are we tracking and how clear are the

outcomes going to be? In addition, are we sure doing so would mean a competitive price point because we have reduced the number of groups willing to contract with such complexity?

- ii. Each managed care contractor will have limited choices for members by service and specialty. A member may end up picking a managed care contractor based on knowledge of their contacted providers.
- 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?
 - i. There is no way a managed care contractor will design service providers around neighborhoods. The companies will design provider availability around reasonable geographic areas, and travel distances will be the measure of reasonableness.
- 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)?
 - i. See above response.
- 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?
 - i. Capacity is a critical issue – if the network cannot support additional members, auto adding more is a problem. While bidding based on lower rates is an appealing idea, there is a fear that rates would be lowered to the extent that benefits are more severely limited leading to lack of adequate care and ultimately greater hospitalization rates.
 - ii. Of equal concern, however is the ability of members to change providers during the year. This allows members to game the system, starting with a fresh benefit slate in mid-year leading to greater overall utilization.
- 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?
 - i. Two years. One year will not be enough to account for variations based simply because of contract implementation issues.
- 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?
 - i. If the managed care company is taking risk, it must have a lock-in period of at least a year.

- ii. Of equal concern is the need to carry over benefit limits between entities so that the member does not double dip on benefits costing the state twice the amount of other members as has been seen in other states like Florida
 - g. If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?
 - i. Enrollment should not be mandated, rather offer at least two choices for care coordination projects and let enrollees choose the one they want; and auto enroll those who do not choose.
 - h. How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?
 - i. Priority should be given to selecting care coordination entities who can manage both Medicaid and Medicare through internal braided income streams that reduce waste and simplify the process for members.
- 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.)
 - i. 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)?
 - i. A basic health plan is critical to help members move from poverty to a more sustainable life style offering some kind of basic healthcare can keep people from slipping back into poverty due to one healthcare problem that takes all their usable income for a few months.
 - 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?
 - i. This would be preferred to minimize member confusion and the risk that a member would get lost in the translation.
 - d. What rights, if any, should the client have to continue a medical home relationship in changing circumstances?
 - i. While it is true that a member who has an effective medical home that helps them reach wellness is better off staying with what work for them, there are issues of scale and cost that are practical and must be addressed. If the medical home is able to meet the price point outlined in the new circumstance, then they should be able to continue. If they are unwilling to meet the price point, the member will need to move to a new medical home.

- e. What mechanisms should be required to obtain client information on an ongoing basis about plan quality? What appeal rights might be necessary?
 - i. Client outcome measures should be published on the HFS website by MCO, ACO and provider agency in the aggregate, but not by individual client.
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?
 - i. Not sure at this time as there is a dearth of information/evidence that this model will yield the desired results.
 - ii. We may consider an ACO role but this may pull us too far away from our mission and so must be carefully considered.
 - iii. If we have a choice between participation with a CCE or still receiving funding when not participating, we will seek to continue our current model and avoid the chaos of moving into a CCE. If we have no choice then we will contract with a CCE.
 - 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. We are exploring the viability of a health home model that is based in a non-primary care entity. We believe we have the right mix of skills and the maximum contact with the members we serve to be the best possible choice for a health home for them.
 - 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?
 - i. While becoming an Accountable Care organization is appealing, it may stretch our organization beyond its stated mission and detract us from fulfilling our primary mission. We are in conversations about this issue.
 - 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?
 - i. See above response. It depends on what we decide to do.
 - 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?
 - i. We are expert at meeting the various needs of individuals living with severe mental illness and those living with intellectual disabilities.

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