Thank you for the opportunity to provide comments regarding the Coordinated Care Program Key Policy Issues. Family Health Network has commented on all of the questions raised by the Department. We are in support of the Department's efforts to expand care coordination to as many Medicaid beneficiaries as possible throughout Illinois. Following are major issues critical to the successful implementation of a Coordinated Care Program.

- Coordinated Care entities must provide all services to beneficiaries, through an affiliated provider network, and demonstrate measurable quality outcomes.
- Actuarially sound rates must be determined for the population to be served.
- Coordinated Care entities must be willing to take fully capitated risk and demonstrate their ability to do so.
- Bonus incentives for demonstrated quality medical care will improve provider participation and encourage preventive health programs.
- National standards for quality are best measured using HEDIS measures and should be used by HFS to monitor and evaluate providers.
- Beneficiary lock-in is required for the care coordination and case management efforts to be successful and measurable.
- The Medicaid physician network is fragile. There is a shortage of PCP's in some geographic areas and an extreme shortage of specialty physicians in many areas. Unnecessary administrative burdens will drive needed physicians from serving Medicaid beneficiaries.
- The Coordinated Care Program must be designed to be administratively efficient for HFS to administer and monitor with its' limited resources.
- HFS wants to consider utilizing additional models of care coordination other than the traditional HMO model. Currently the Managed Care Community Network (MCCN) is an outstanding alternative model that has proven successful for Illinois.
- Additional providers can organize Coordinated Care entities under the MCCN regulations if they commit to serving the Medicaid population, fulfill the capital requirements, take full financial risk and agree to the same contractual requirements that plans must meet in the current Voluntary Managed Care Program. On this last point, if a couple of Safety Net providers could organize and commit to fulfilling these requirements, anyone stating they can not would seem disingenuous.

Family Health Network is a Safety Net provider sponsored organization committed to the Medicaid population. FHN has been providing coordinated care for its enrollees and will continue to participate with HFS as it seeks to provide improved health care to a broader population in the future. We are committed to the Care Coordination Program in Illinois.

Respectively submitted,

Keith Kudla, President & CEO
Family Health Network

Illinois Coordinated Care Program
Written Comments submitted by Family Health Network

1. How comprehensive must coordinated care be?

a) Family Health Network recommends that the Coordinated Care Program contract with entities that both agree to arrange care for the entire range of services available to a client and demonstrate their ability to do so. The current Voluntary Managed Care Program requires MCO's to arrange for all Covered Services. To allow Coordinated Care Program contracting organizations to do any less will result in fragmentation of care, which would appear to be contrary to the intent of the Medicaid reform law adopted by the Illinois General Assembly. Beneficiaries need assistance with accessing all types of care throughout the health care delivery system so the exclusion of any services from the program will mean that some beneficiaries will not get the coordination assistance they need. For example, it is essential for the Coordinated Care Program to include both medical and behavioral services because this results in better and integrated care for beneficiaries. The Coordinated Care Program should not exclude specific services from the requirement that they be coordinated. It is our view that the State of Illinois will get the best results for the State and its beneficiaries through a fully capitated managed care program. This program should include provisions to reimburse plans appropriately for adverse selection and should utilize techniques such as risk adjustment, risk corridors, and for small start up entities, reinsurance.

   In order to create a program that is manageable for the State to administer, we believe that it will be necessary to limit the number of model types and standardize these models. Illinois State law already allows regulatory flexibility for alternative delivery models to grow and flourish. First, there is the traditional Health Maintenance Organization (HMO) regulated by the DOI. However, over 10 years ago Illinois passed legislation to allow the creation of Managed Care Community Networks (MCCN). As you know, the MCCN legislation allows medical provider governed not-for-profit entities to form and participate in the Medicaid Managed Care Program. The intent of this legislation appears consistent with the Department's goal of contracting with entities that operate closer to the actual delivery of care. The legislation lowered the "barriers of entry" into the Medicaid Managed Care Program allowing alternative models to enter. The motivation for the creation of these alternative models by medical providers was the advent of mandatory enrollment into Medicaid Managed Care at the time. When mandatory enrollment did not materialize all of these entities eventually disbanded except of Family Health Network which has continued to coordinate care (at full risk), serving the Medicaid population for over 15. With the advent of mandatory enrollment into Medicaid managed care once again upon us, the MCCN framework will foster alternative models. Whether an HMO or an MCCN, all entities sign identical contracts with HFS with the same requirements and standards such as arranging for <u>all</u> Medicaid Covered Services in the contract. A standardized contract will create a program that the State can manage and monitor effectively and more efficiently. It will also create less confusion for beneficiaries and providers. Finally, it will enable critical assessment of cost, quality of care, access to care, and outcomes across participating entities.

b) It will be important for each organization that participates in the Coordinated Care Program to agree to arrange for all Medicaid services initially. In addition, we believe that the State will get the best value by requiring organizations participating in the

program to assume risk for most, if not all, Medicaid services, with the possible exception of select services such as long-term care services. If the State offers more than one model of care, contracting provider organizations should have the opportunity to participate in multiple models. This will encourage contracting organizations and the State to identify the most successful attributes of the models for future program enhancements.

c) Initially the program should require that each beneficiary have a selected/assigned primary care provider or "medical home." The primary care provider must initially have basic responsibility for care coordination such as referrals to specialists as well as responsibility for preventive and routine care of the beneficiary. Over time, the Coordinated Care Program may introduce additional requirements for a medical home, but the State would accomplish a great deal towards providing better quality of care to beneficiaries simply by taking the first step and creating a program that establishes a relationship with a primary care provider with the basic tools to reinforce the medical home such as a specialty referral requirement, a beneficiary medical ID card with the PCP's name and phone number, a contracted specialty referral network, etc. Additional requirements could be placed on primary care providers over time, but consideration needs to be given to whether there are sufficient primary care providers available and willing to see Medicaid beneficiaries and whether additional requirements will discourage their participation in the program. It may be desirable for care coordination to focus on providing support to primary care providers rather than placing additional burdens on them.

   Traditionally managed care organizations have performed the essential functions of a medical home. The following functions are critical to a successful model of coordinated care:

   - **Consistent access to primary care**, regardless of time of day or night.
   - **Patient-centered care coordination** at the primary care provider level that effectively addresses chronic conditions and the unique needs of the Medicaid beneficiary.
   - **Emphasis on quality and safety**, including the use of information technology wherever possible.
   - **Improved communications and education**, between providers and patients, to address issues such as health literacy, cultural sensitivities, language barriers and adherence to care plans.
   - **Alignment of incentives for providers**, such as using pay-for-performance and other tactics.
   - **Team-based care**, which encourages a multi-disciplinary approach to care.

   HFS should require all potential Coordinated Care Program entities to address the essential functions described above to insure they can be adequately provided to all Medicaid program participants. However, HFS should be careful, at least initially, not to place too much burden on specific providers. For example, many of the PCP's that serve the Medicaid population are near retirement. When we inform them that they will eventually have to convert to Electronic Medical Records, some of them simply state "no I won't, because that is the day I retire."

   Requiring a medical home to have NCQA certification will create a huge barrier to participation and add significantly to the administrative costs for organizations desiring to participate. Practically speaking, even if an entity decided today to participate in the

Coordinated Care Program in the fall of 2013, it is unlikely they could attain NCQA certification by that date. If the State decides NCQA certification should be a requirement, we recommend a 3 year transition period from the effective date of the Coordinated Care Program. As described below, EQRO monitoring could provide necessary oversight in the interim. Illinois currently has a shortage of both primary care providers and specialists (especially pediatric sub-specialists) available and willing to care for Medicaid beneficiaries. The additional reporting, tracking and participation requirements related to becoming an NCQA certified medical home, combined with the reimbursement available in Illinois will likely cause a large number of physicians to withdraw from participation in any Medicaid programs. The State has the responsibility to measure quality of the Coordinated Care Program entities. This should be done using the External Quality Review Organization (EQRO) model for monitoring contractual compliance. Currently the State of Illinois HFS contracts with an EQRO to monitor the managed care organizations. That program has been very successful in both monitoring quality and coordinating quality improvement projects to improve the health status of Medicaid beneficiaries.

d) Requirements should primarily be focused on the outcomes of care coordination (e.g. HEDIS, HRA) rather than the process. Care coordination is an ever evolving science focused on improving health outcomes and population health. Family Health Network continually seeks the most effective use of the limited resources available in the Medicaid Managed Care Program to improve health outcomes and population health management through care coordination and other means. In addition, other factors can change requiring an organization to redirect its focus and resources. One example is the expanded Medicaid eligibility effective January 1, 2014 which will dramatically change and expand the health needs of the Medicaid population. An organization should have some flexibility in determining how it will coordinate care. However, the Care Coordination Program could require some critical process outcomes as in the Voluntary Medicaid Managed Care Program such as health surveys, HRA's where indicated, risk stratification and care plans. In the current Voluntary Managed Care Program the MCO's are required to have a Care Management Program which begins with a health survey of all members. Those members identified as needing care management services participate in an extensive health risk assessment to identify the disease specific needs of the member. For example, asthma is a significant health issue for the Medicaid population in Illinois. The care coordinator works in a team based approach with the PCP, specialists, the patient and the parents to develop and monitor an Asthma Action Plan. The goal of this effort is to assist the patient to control their disease through education, medication and medical compliance, and controlling environmental factors. Members not requiring a care coordinator for a specific medical condition are provided out reach and education on prevention and detection health measures such as immunizations, well child visits, mammography and cervical cancer screenings.

e) Wherever savings can be achieved, the State should participate. For example, State Rx agreements, transplant agreements and interstate provider agreements should be created on behalf of all entities providing care to Illinois residents.

Most importantly, the State should encourage all medical providers, including physicians and hospitals, to provide care to participants in a Care Coordination Program. Similar to other States, medical providers should protected from less than Medicaid reimbursement rates by requiring plans to pay at least 100% of the Medicaid fee schedule. Georgia is one example of a state that requires its plans to do this. However, Georgia also mandated

that Health Plans need only pay 90% of the Medicaid fee schedule for Emergency Room services to hospitals that refused to participate in the Medicaid managed care program if health plans had made good faith efforts to contract with that hospital. In addition, Illinois could use Medicaid funds that do not flow through the Coordinated Care Entities as an incentive to encourage Medicaid participation.

The State can also help in other ways. It should require the completion of a Health Risk Survey at the time of Medicaid determination and/or redetermination. This is a much more cost effective mechanism to gather the needed information than requiring the plans to make repeated attempts to find a member to complete the Health Risk Survey after they are in the system. If the Health Risk survey is done at the time of the determination, the plans could implement care coordination follow-up more rapidly. Plus, it will ensure health surveys are completed on 100% of the population versus the less than 50% that is achievable after enrollment.

The State should also develop a plan to acquire updated demographic information on beneficiaries and provide the information to the contracting entities of the Care Coordination Program. This approach would help insure that all benefits administered by the State are delivered to the intended recipients and to insure the recipients receive the needed information from both the State agencies and the providers of medical care.

The State should organize a major effort through the MCHC Health Information Exchange Project requiring hospitals to share emergency room visit information with the Care Coordination entities. By using the Illinois HIE as the source of information, there would be standard communication protocols, eliminating various duplications and inconsistencies in transferring medical record information needed for timely and comprehensive care coordination.

f) In addition to increased reimbursement, an incentive would be to make sure that providers do not feel burdened by administrative requirements. The development of actuarially sound rates for subsets of the population with complex medical needs (e.g. Risk Adjusted Capitation Rates) and for “super specialists” would reduce concerns of significant adverse risk.

It is important for members to have a lock-in period of time for the enrollment with the Care Coordination entity. If providers are “doing the right thing”, they will make the effort to address all of the patient issues and develop a strong care management plan for the patient, but if the patient then leaves the Care Coordination entity, the economic incentives will not be realized. This situation will result in frustration and cause providers to exit the system.

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

a) Family Health Network strongly agrees with the State’s intention to choose measures that are nationally accepted. Specifically, we recommend using select HEDIS measures. Utilizing the same quality measures that are used by other payors, and that are nationally recognized, will eliminate confusion for the participating providers and will enable providers to focus their efforts on improvement for a larger proportion of their patients. The measures selected should reflect the population enrolled in the Coordinated Care

Program. For example, HEDIS measures for preventive well-child visits, immunization status, prenatal care, post partum care, preventive women's services such as cervical cancer screening and mammography, behavioral health follow-up after admission, medical/surgical readmission rates, as well as common disease indicators for asthma and diabetes are very appropriate for the population. Implementing measures for the Care Coordination Program that are different from those that are used for other programs will create additional burden for providers and dilute the effectiveness of the actions that providers and plans take to improve outcomes.

b) We believe that the Department should select a set of measures that are used by other payors and that have proven to be valid measures. The HEDIS measures identified above reflect the goal of age adjusted appropriate care. Some of these measures assess the care that is delivered to individuals with chronic diseases like diabetes and asthma. These measures are appropriate for the Medicaid population. Measures that assess the quality of care for conditions that are less common will require sizable enrollment in an individual plan and should be phased-in after the successful introduction of proven measures that assess the care delivered to larger numbers of beneficiaries.

c) The basic measurement of quality across the entire population can be evaluated using the HEDIS measurements identified above. We recommend that HFS go to one methodology, bonus incentive over capitation, and away from the current complicated payment system of both a withhold and bonus incentive. This will be much easier for both the State and the contracting entities to administer. A bonus program is more positive and encouraging for the providers than a withhold program. In addition, one of the positive aspects of the current pay for quality program in the Voluntary Managed Care Program is that it takes into consideration quality improvement. The effect is to level the playing field with patients across a wide range of situations by focusing on the improvement the care coordination entity achieves. If a withhold is to be utilized, it must be actuarially sound relative to pre-care coordination enrollment.

d) The measures the Department selects should reflect the priorities of the State; however, please strive for focus as each additional measure adds administrative burden and dilutes the focus of providers. Since Illinois HFS has experience in measuring HEDIS or modified HEDIS measures, most medical providers are very familiar with using them to measure quality. HFS has used HEDIS for measuring both the Voluntary Managed Care Program and the PCCM Program (Illinois Health Connect).The main obstacles to the collection of HEDIS data are accurate coding (CPT Procedure Coding and ICD Diagnostic Coding) and the submission of complete encounter data by providers. The data is needed to document that care has been given, but many providers view the technical aspects of submission to be costly and an administrative burden in a capitated risk based financial model.

e) The incentive must be material enough to drive behavior. One proxy is to base the incentive on the cost of providing the additional services. For example, if the State sets a goal to increase mammography rates 50% then the incentive should compensate for those additional services. Assuming the payment is to a care coordination entity responsible for providing a broad range of medical services including hospital, there may be some offset.

f) The Department should utilize measures that are being utilized by other payors and collect information in the same way that other payors are collecting this information.

This will encourage their participation in the Coordinated Care Program. The use of HEDIS measures is the way to set clear measures because HEDIS measures are currently used in Illinois and throughout the United States.

g) Broadly speaking, utilizing HEDIS will allow you to measure success by comparison to published benchmarks. Specifically, success should be measured in a variety of ways, including (1) improvement in HEDIS rates of select measurements (2) a decrease in hospital re-admissions; (3) a decrease in admissions to hospitals for conditions that could be treated on an outpatient basis; and (4) a decrease in the number of unnecessary emergency department visits.

3. To what extent should electronic information capabilities by required?

a) Initially, the Coordinated Care Program should require that each organization describe how it will ensure that effective communication among providers takes place, regardless of the method of that communication. Until electronic medical records and health information exchanges are in place for all providers, and information is shared easily and effectively, it is important to focus on the existence of effective communication in any form: this could include faxing, phoning and emailing the necessary information.

The Medicaid provider network in Cook County is currently very fragile due to the payment system, age of providers, cost of malpractice insurance, and what providers view as burdensome administrative requirements from the State and MCO's. To require EMR's at this time would likely drive many providers away from treating the Medicaid population resulting is a major shortage of providers. But, standardized medical record requirements and the requirement of standardized medical record forms would be a significant step forward and prepare an office for successful implementation of electronic medical records. The standard record forms would need to be age appropriate and several very acceptable forms have already been developed for use in other states with active care coordination models in place.

b) Our suggestion would be that the Department not offer bonuses that would likely result in lower reimbursement, making the Coordinated Care Program less attractive to the providers. Clearly, some medical offices will not implement EMR's until physicians retire and sell their practices or merge the practices with health systems providing IT support.

c) FHN does not support the State of Illinois supplementing some select providers for information technology with funds intended for the care of patients. The EMR is a means to an end, and the focus should be on the end, which is the results and improvement in coordinated care.

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

a) Our understanding is that the Department is considering alterative risk arrangements to foster alternative care coordination models that will be offered by the people closest to providing that care (e.g. medical providers). This goal has already been accomplished in Illinois. In 1999 Illinois passed legislation to allow the creation Managed Care Community Networks (MCCN). As you know, the MCCN legislation allows medical provider governed not-for-profit entities to form and participate in the Medicaid Managed

Care Program. The intent of this legislation appears consistent with the Department's goal of contracting with entities closer to the actual delivery of care. The legislation lowered the "barriers of entry" into the Medicaid Managed Care Program allowing alternative models to enter. The motivation for the creation of these alternative models by medical providers was the advent of mandatory enrollment into Medicaid Managed Care at the time. Several MCCNs were formed at the time and participated in the Medicaid Managed Care Program. When mandatory enrollment did not materialize all of these entities eventually disbanded except for Family Health Network which has continued to coordinate care (at full risk) serving the Medicaid population for over 15 years. With the advent of mandatory enrollment into Medicaid managed care once again upon us, the MCCN framework will foster alternative models. We do not need to "re-invent the wheel." The MCCN framework provides a vehicle for many alternative models to form. Now, as then, these entities should be willing to accept full risk for the cost of care delivery under a capitated model that will focus them on delivery of efficient, high quality care focused on outcomes. The State would be best served by ensuring that "at risk care coordination" entities have the flexibility to pursue innovative reimbursement methodologies rather than attempting to do this at the State level.

We strongly recommend a full risk capitation model and the State could implement one or more of the risk mitigation strategies below within the model:

- Limit enrollment in the care coordination entity consistent with risk based capital.
- Implement a risk corridor until the entity's membership reached sufficient size to "spread" adverse risk. For example, Federal CMS guidelines limit the incentive and at risk payment to providers to 33% of the capitation paid by the payer until the providers membership exceeds 1,000.
- Reinsurance or Stop Loss protection against catastrophic cases that could be offered on a voluntary basis to small or "start-up" entities for which a premium would be charged to the coordinated care plans choosing to participate.
- Risk adjusted capitation payments to ensure care coordination entities are provided sufficient resources to care for the members who select or are assigned to them.
- If the State were to implement health surveys upon Medicaid eligibility, health status could be a member assignment criteria to ensure health risk is spread evenly across the coordinated care entities. Initially the State could use FFS claims data.
- While not consistent with a full risk capitated model, care coordination entities that only desire gain sharing should be required to take proportionate down side risk. For example, if the entity wants 50% of the gain share then they should be required to take 50% down side risk.

b) See "a" above.

c) See "a" above. The risk mitigation strategies mentioned above should not be permanent, but phased out over 2 to 3 years. The State should not stay in the "reinsurance" or "risk mitigation" business indefinitely.

d) See "a" above.

e) FHN supports minimum Medical Loss Ratios. The 80% set by ACA appears to be a good starting point and is the current MLR Guarantee in the Voluntary Managed Care Program for the TANF population. Under the current MLR calculation rules in the Voluntary Managed Care Program, a minimum MLR as high as 85% would be appropriate if the State were to eliminate marketing and implement mandatory enrollment into a

coordinated care plan, with auto-assignment consistent with Federal Guidelines, at least a 12 month lock-in period (with a 60 day free look period), and required that all participating coordinated care plans are actually coordinated care plans with full risk capitation. The items listed above as well many others can materially affect the appropriate level of a minimum MLR. The population being served is also a major factor. For example, all else being equal, the minimum MLR for the ABD population would appropriately be set much higher than that for the TANF population. The financial rules used for calculating the MLR are also critical. Under the Voluntary Managed Care Program the MLR is calculated using the financial rules determined by the National Association of Insurance Commissioners (NAIC). They are determined by a third party and create minimal administrative burden on the plans because they already calculate the MLR for their State statutory filings. In the Integrated Care Program the MLR is calculated using an encounter based system. Conceptually, we understand the attraction of an encounter based calculation. Practically, we are concerned with the administrative feasibility. In addition, an encounter based calculation will preclude innovative provider reimbursement methodologies that drive efficient, high quality care to improve outcomes. In other words, an encounter based calculation is essentially a fee-for-service based calculation which in turn boxes the coordinated care plan into a fee-for-service reimbursement system for providers. Using financial rules established by NAIC or being developed for the Health Exchanges is appropriate and will allow coordinated care plans to implement innovative reimbursement systems that have been developed or are being developed to improve quality of care, reduce cost and drive better outcomes.

f) The coordinated care entity should accept risk. A risk-bearing organization will engage in negotiations with providers that will result in contracts that provide terms for reimbursement. It should be the responsibility of the coordinated care organization to determine the best methods to reimburse providers that are both agreeable to providers and achieve the best outcomes for the beneficiaries and the state. FHN works with providers to determine their risk tolerance. The Coordinated Care entity should have the ability to provide a host of arrangements for the providers based on their ability and desire to be at risk. Please be mindful of whoever you delegate risk too, you must also regulate and monitor their financial solvency. The Illinois Department of Insurance addressed this issue about 10 years ago. After extensive public comment and review the DOI decided to stipulate health plans were accountable for the financial solvency of any provider to whom they delegate financial risk.

g) FHN supports risk adjusted premium so that entities are properly reimbursed to care for the members enrolled. The net effect of risk adjusted premium is that entities are rewarded for effectively managing risk (i.e. the health status of their members) versus being rewarded for avoiding high risk members (e.g. high needs children). Federal CMS risk adjusts premium in the Medicare Advantage program based on the diagnosis of the members submitted by the participating plans. The risk adjustment should be done at the level of the individual beneficiary, utilizing the State's FFS claims data for the beneficiaries who were enrolled in FFS prior to enrolling in the Coordinated Care Program. Subsequent to enrollment and annually thereafter, the State should risk adjust based on the diagnoses encounter data submitted by the coordinated care plan in a system that is similar to that used for the Medicare Advantage program.

Stop loss and reinsurance are valuable risk mitigation strategies. As mentioned in "a" above, the State may want to offer these options to start-up or smaller plans on a voluntary and temporary basis as risk management option. The reinsurance program should be

temporary because there is significant "moral hazard" in reinsurance that is best left to the reinsurance companies to manage over the long term.

h) There are several ways that the state can assure that capitated rates are not used to limit appropriate care. We have listed many below in no particular order of priority. Most of these safeguards are in place in Illinois' Medicaid Managed Care programs today:

- Ensure that the capitation rate is actuarially sound and risk adjusted. This will ensure the good performing coordinated care plans have adequate resources to provide appropriate care to members.
- EQRO auditing. The EQRO audit performs many valuable functions. For example, it evaluates the appropriateness of the plan's care management policies and ensures they are being carried out. It audits to see that health surveys are being completed, HRA's are done when indicated, appropriate care plans are developed and implemented. Also, the EQRO ensures that the plan's provider credentialing criteria are adequate and that providers are being held to those criteria. The EQRO audits is auditing for compliance with the health plan's contract with the State. As we have previously mentioned, all coordinated care plans should be held to the same high standards and requirements. First and foremost, those standards and requirements must protect the Medicaid Beneficiary.
- Measures for assessing quality (e.g. HEDIS) by which the State will monitor whether appropriate care is being delivered.
- Implement an enrollment lock-in period. Organizations that operate under full capitation actually have an incentive to detect illness and treat patients early as possible in order to prevent expensive complications that will occur later. Adding a lock in period increases this incentive. Beneficiaries should be allowed to switch health plans during the lock-in period for appropriate reasons. For example, if the beneficiary's PCP ceases participation in a coordinated care plan then the beneficiary should be able to switch to a plan in which the PCP continues to participate. However, equally important is to assess if the beneficiary is attempting to change plans for inappropriate reasons such as limitations of appropriate care.
- Replace direct sales with mandatory enrollment into coordinated care plans, with equitable performance based auto-assignment consistent with Federal Guidelines, and a 12 month lock-in period (with a 60 free look period). This will prevent another "AmeriGroup" type debacle as new health plans enter the market.
- Ensure that the coordinated care plans have adequate contracted provider networks that can provide Covered Services. One such requirement may be to ensure that before a plan can assign members to a PCP, they must have at least one hospital in their network with which that PCP is affiliated or have a written alternative admitting agreement. By not having this requirement, a plan may indirectly be limiting appropriate care and driving adverse risk to other coordinated care plans.
- Ensure the coordinated care plans have compliance plans and employee training. Our training encourages employees to report fraud, waste, abuse, or non-compliance with our State contract by FHN or anyone engaged in the Medicaid Program.
- Maintain the Medicaid Hotline. HFS maintains a hotline where among other things; beneficiaries, providers, employees or any interested party can report that they believe appropriate care is being withheld.

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

a) There is widespread recognition of the need to find alternative strategies for delivering health care. Innovation in health care delivery is beginning, most notably in the Medicare program. While we recognize the need for these innovations and the desirability of their success, we believe that the successful enrollment of half of all Illinois Medicaid beneficiaries into the Coordinated Care Program in the next two years will require the State to rely heavily on programs that have a proven track record of managing risk and the Medicaid beneficiaries. It is important for all entities, whether traditional managed care organizations or alternative organizations, be held accountable to the same standards of service and care. Alternative care delivery models should be supported. FHN, a Safety Net Provider Sponsored not-for-profit health plan, is an alternative to what HFS commonly refers to as the "traditional Managed care entities." The model is highly successful and provides an alternative to thousands of Medicaid beneficiaries desiring coordinated care through the not-for -profit provider sponsored network. Illinois enacted the MCCN enabling legislation over 10 years ago to foster the development of alternative delivery models. However, aside from the MCCN regulatory framework, MCCN's are held to the same requirements as "traditional managed care entities" (i.e. the managed care contract with HFS). If a couple of Safety Net providers can form an MCCN like Family Health Network, put up the necessary capital, take full risk capitation and agree to the same contractual requirements as the traditional managed care entities; anyone stating they can't would seem disingenuous.

b) It is important that the Illinois Department of Healthcare and Family Services be engaged in ensuring that any organizations that take risk have sufficient financial reserves to protect Illinois consumers, providers and the Illinois tax payer. In the case of Family Health Network, as a Managed Care Community Network (MCCN), we are regulated by HFS and required to hold reserves as well as submit audited financials. Department of Insurance certification should not be required as long at the entity demonstrates financial solvency. We do recommend that the State review the reserve requirements of an MCCN. The legislature may not have contemplated MCCNs becoming as large as FHN. The reserve requirement is not adequate for large MCCNs and FHN does hold substantially more reserves than mandated. The DOI's Risk Based Capital Requirement (RBC) may be an alternative as it mandates reserves appropriate for even the largest health plans. The RBC calculation is a bit complicated but usually dictates health plans maintain reserves equivalent to 5% to 7% of premium. HFS could greatly simplify the approach by requiring MCCNs to hold reserves equivalent to 1 month premium.

c) As long as all of the administrative, financial, quality and coordination of care requirements are met, there need not be a minimum number of enrollees initially. At some point HFS may want to stipulate minimum enrollment required to continue in the program for the reasons you state. Requiring entities to cover geographic areas large enough to accommodate patterns of care (e.g. at least one county) could ensure adequate enrollment. We are confused by your last sentence as one-sided arrangements do not entail the care coordination entity taking any financial risk. If you offer one sided agreement, you probably will have so many entities participating that you will not have "the administrative resources necessary to accommodate them and monitor them."

d) The network of providers should be extensive enough for care coordination entity to provide "substantially" all covered services under the contract. The network of providers should be a contracted network of participating providers that also reflects the patterns of care in that geographic area and/or adequate geographic access. The entity, in all cases,

should be required to arrange for appropriate medical services regardless of whether that service is available from a network provider or not. Even if the service is available from a network provider, that network provider must be reasonably accessible (geographic or otherwise) to the member. If not, the entity should be required to provide the care from a non-network provider that is reasonably accessible. The network must be geographically accessible for the enrollees. Excessive distance for primary care providers is a deterrent to accessing needed medical care.

e) Yes, if the population of clients is large enough that more than one entity is available to serve those clients. Federal CMS has enabled Special Needs Plans focused on serving chronic or severely ill clients. If you risk adjust premium as we have recommended such entities are feasible. We assume the State will segment the ABD population from the TANF population. Clients in the ABD population will be drawn to entities that best meet their needs. The State must ensure through risk adjusted premium that the entities are provided sufficient resources to care for the high need clients.

6. What should be the requirements for client assignment?

a) We do not believe this is appropriate or feasible. Clients should be able to choose among all coordinated care plans that are available in areas where they live. If the state requires contracting entities to be responsible for all services, there is no need for specialty networks as Care Coordination entities. The specialty networks will contract with the contracting entity or entities. This will reduce the administrative load on HFS to allow adequate regulatory oversight.

b) Family Health Network suggests that the Department create service areas and that each coordinated care entity be required to cover an entire service area or areas. These service areas should be consistent with the health care delivery patterns in the area, include a sizable number of enrollees, and should be feasible for the state to administer. Experience shows that the Medicaid population is very transient within a geographical area, such as Cook and the collar counties. “Neighborhood” plans would not be acceptable to provide the coordination of care and range of services needed for a successful Coordinated Care Program. “Neighborhood” plans would increase churning of enrollees base upon the transient nature of this population. We believe that the current service area requirements in the Voluntary Medicaid Managed Care Program are appropriate and have served the State well.

c) Providers that have developed expertise in serving certain types of patients should not be forced to change the nature of their practice. We recommend that these providers serve as subcontractors to the entities that choose to take risk in the Coordinated Care Program. Segmenting the population beyond ABD and TANF will create complexities, unintended outcomes and increase administrative costs for the State.

d) Obviously, informed and educated self-selection is the best way to determine enrollment. Illinois should look at models of auto-assignment methodologies in other states for program implementation. Alternatives to random auto assignment include: established PCP or medical home based on claims data, performance based enrollment based on quality indicators and demonstrated outcomes; established care management programs ; auto assignment based on proportion of beneficiary selection; access to care based upon completeness of the network of providers; other family member in the same entity; and equitable distribution.

e) Bidding on spots could prove counterproductive in a population where extensive outreach is needed. This option would be complicated and lend itself to organizations bidding low and then unable to provide the needed services. We recommend that the State set actuarially sound and adequate rates and then auto-assign based on criteria related to access to care, quality of care and service. Some of those criteria are mentioned in "d" above.

f) We support performance based auto assignment and recommend the State convert as soon as feasible.

g) Lock-in is absolutely a needed principle in the Coordinated Care Program. In successful care management programs, there is significant financial investment and professional investment to change the course of a members' disease. To engage providers in the care management concept, they must realize that dollars spent to educate members, change their life style and follow care plans will pay off in the long term. We believe the lock-in period should be at least one year (with a 60 day free look period). There should be limited reasons for a beneficiary to change plans. If unlimited "switching" or "churning" is allowed to occur, the State will also have an unnecessary administrative burden. Reasons to allow a person may include relocation to a geographical area where the current provider organization does not have contracted providers or behavior of the beneficiary is unacceptable to providers and staff. Enrollees who continue to remain non-compliant should be warned and then taken off the Medicaid benefit program.

h) We don't think enrollment could be mandated under Federal law. To mandate enrollment into managed care plans, beneficiaries must be afforded adequate choices.

i) Family Health Network is very interested in the issue of coordinating care for persons who are dually eligible for Medicare and Medicaid. These issues are very complicated and we would suggest that this be handled outside of the Coordinated Care Program. However, we are aware that Federal CMS is very willing to work with States that want to implement coordinated care programs for dual eligibles. FHN is very interested in working with the State to implement such a program.

7. How should consumer rights and continuity of care be protected?

a) If entities enter and leave the market frequently, the result will be a great deal of confusion for providers and beneficiaries and a great deal of administrative effort for everyone involved in the program. For this reason, we suggest that the State contract with entities with experience in coordinating care and limit the number of models with which it contracts. We recommend either an HMO licensed through the DOI or an MCCN approved by HFS to allow alternative models. Either regulatory framework requires the care coordination entity to demonstrate their commitment and ability to serve the Medicaid population. Combined with the requirements and standards of care, access to care, service to beneficiaries and full risk capitation through a contract such as that used in the Voluntary Managed Care Program today, you will filter out most care coordination entities that are not truly committed, sustainable or able to serve the Medicaid population. HFS should combine efforts with State staff planning the health exchange to insure contractors in the Coordinated Care Program can and will also participate in both programs. This will allow for continuity of care and a smooth transition of clients to and from the Medicaid Coordinated Care Program and the Health Exchange. Beneficiaries

could then retain their medical home and continue in the care coordination plan without interruption.

b) Family Health Network believes that the implementation of a Basic Health Plan that contracts with the same organizations that participate in the Coordinated Care Program will allow individuals to stay with the same health plan whether they are covered by Medicaid or eligible for coverage through an Exchange and have income under 200% of poverty. A Basic Health Plan that contracts with Medicaid health plans will also allow all members of a family to be members of the same health plan even though some are eligible for Medicaid and some are not. Family Health Network encourages that State of Illinois to consider the development of a Basic Health Plan. We have provided information on the Basic Health Plan Option to HFS in the past and highly recommend you consult with Stan Dorn from the Urban Institute who is one of the foremost authorities on the Basic Health Plan option. A Basic Health Plan would alleviate most of the "churn" at the 133% FPL. As mentioned above we also recommend that the State facilitate participation in the Exchange for care coordination entities participating in the Medicaid Care Coordination Program such as allowing a 3 year transition period for the accreditation requirement in the Exchange. Current EQRO audits conducted in the Managed Medicaid Program today could satisfy the requirement in the interim. Allowing MCCN licensure to satisfy the "licensure" requirement in ACA for qualification in the exchange would facilitate alternative delivery models to participate in the exchange. However, we do recommend that the State strengthen the financial solvency requirements for MCCNs to be more consistent to that required by the DOI. While the "start-up" capital requirements for HMO licensed by the DOI or an MCCN are similar, the MCCN financial solvency requirement for large coordinated care plans is not and we believe insufficient to protect beneficiaries, providers and the Illinois tax payer.

c) The State should not require plans that participate in Medicaid to participate in the Exchange, but they should assist and encourage them to do so as described in "b" above. While FHN plans to participate in the Exchange, a requirement to do so as a condition of participating in the Medicaid Care Coordination Program may preclude the participation of alternative models which appears contrary to the goal of HFS to encourage such models.

d) The client should be able to keep an established medical home relationship as long as the provider participates in the Coordination of Care Program and meets the required quality standards for participation with a contracting entity.

e) If a client seeks information about quality, they should be given the information needed to make health care decisions. If a client has problems, there should be a system for easy problem resolution.

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

a) FHN is an ACO by definition – a provider governed not-for-profit entity responsible for the full continuum of care and accountable for cost and quality. Under Illinois law Family Health Network was formed as a Managed Care Community Network by Safety-Net Hospitals in Chicago. The network expanded to insure specialty and ancillary services are available for our enrollees and to insure we have excellent coverage throughout Cook County Illinois. Late last year FHN embarked on a network development program and the

response has been astounding. By the end of this year FHN will have added over 1,000 new providers including more than 250 primary care providers. FHN is prepared to expand in other counties and submitted an application to HFS to extend its service area into Kane County in November 2010. HFS has not acted on the request because of the moratorium on health plan expansions at this time (Note: we do not disagree with the decision). We are committed to continue to serve the Medicaid population in Illinois. This has been demonstrated throughout the years as our growth has been successful and our health outcomes very good. Currently FHN coordinates the full range of medical and behavioral services for over 60,000 beneficiaries that have selected the health plan.

b) FHN supports a full risk capitation model. We encourage the Department to create more incentives for quality. Our organization is unique due to our commitment to serve those who would otherwise not have access to quality medical care. We serve this mission not just through member enrollment in our health plan, but also through support of safety net providers.

c) We are evaluating the Medicare ACO concept at this time.

d) As a current contractor of HFS for the Medicaid beneficiaries, we are ready, able and willing to expand the number of beneficiaries we serve. We have recently made significant upgrades to our Care Management Program, including computerized software, the addition of professional and non-professional staff, and created an organizational culture of quality excellence for our members. FHN is also embarking on a multi-million dollar upgrade to our core Information Technology Systems to a market leading system that will allow us to "scale up" to serve 200,000; 300,000; 500,000 or more members.

e) As stated in "d" above, FHN is currently serves over 60,000 Medicaid clients and is growing rapidly. We are making the necessary investments to ensure we can "scale up" to serve a half million clients or more. Our expertise is caring for the TANF population. We are very willing to discuss the Care Coordination Program for all populations with HFS. We are currently partnering with a specialized organization in discussions with HFS to serve a "high need" Medicaid client population. Our goal is to expand the organization to provide care for the under served populations. That is the mission of our sponsoring hospitals and Family Health Network.