

TASC

Treatment Alternatives for
Safe Communities

Response to HFS Coordinated Care Discussion Paper

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July 1, 2011

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THE COORDINATED CARE PROGRAM
KEY POLICY ISSUES
TASC ILLINOIS
WRITTEN COMMENTS

Introduction	2
Criminal Justice-Involved Populations and Coordinated Care.....	6
Who is TASC Illinois – Background and Introduction.....	9
TASC Capabilities Statement.....	11
1. How comprehensive must coordinated care be?.....	14
2. What should be appropriate measures for health care outcomes and evidence-based practices?	17
3. To what extent should electronic information capabilities be required?	21
4. What are the risk-based payment arrangements that should be included in care coordination?	24
5. What structural characteristics should be required for new models of coordinated care?	27
6. What should be the requirements for client assignment?.....	28
7. How should consumer rights and continuity of care be protected?	30
8. What is your organization’s preliminary anticipation of how it might participate in coordinated care?	34
References	40

Introduction

The expansion of Medicaid eligibility through the Affordable Care Act (ACA), beginning in 2014, will dramatically change the landscape in Illinois regarding access to medical services. Thousands of low-income individuals whose untreated substance use and mental health disorders bring them into contact with the criminal justice system will become eligible for Medicaid, affording them unprecedented access to medical and behavioral health services.

Due to high rates of unemployment and ineligibility for Medicaid under current rules, this population has little experience with health care outside of emergency rooms and jails. Disconnected episodes of acute care form the least effective and most expensive response to chronic medical conditions, substance use disorders and mental health conditions. Novel strategies are needed to create better outcomes for this and other high-risk populations. Innovative outreach, enrollment and engagement strategies will be needed to fully integrate this population into ongoing care in the community.

More than 200,000 individuals are involved in jails, probation and parole in Illinois each year. Far from being a niche population, this group will comprise at least one quarter of the 500,000-800,000 expected new Medicaid enrollees after 2014.

TASC is submitting this response because we believe this expansion of insurance and access to care will have a significant positive impact on individuals, families and communities. Illinois faces a tremendous opportunity to reduce state health care costs, improve health outcomes and reduce state expenditures for incarceration, improving both public health and public safety. We encourage the State to fully leverage this opportunity.

TASC is one of Illinois' leading providers of services to this population, operating as an essential link to the community for those preparing for, reentering or already reintroduced to community life. Available data concerning individuals involved with the criminal justice system is summarized here to further understanding of the proportions of this population, the prevalence of mental health (MH) and substance use disorders (SUDs) within it, and the broader health needs its members exhibit, particularly for costly, chronic conditions. For both commercial and public health plans and the actuaries who forecast utilization, this data has historically been obscured. Increasing the transparency of the data highlights the level of need that must be addressed for Coordinated Care Organizations (CCOs) to succeed. Note that the majority of the data utilized is national; it should be generalizable to Illinois within limits. Where Illinois specific data is used, the distinction is noted.

We are providing this introductory section to our submission as a way of clarifying the status and interactions between the individuals engaged in some fashion with the criminal justice system who are also very likely to become participants in CCOs. We believe this is a necessary step in clarifying our responses to the Department of Health and Family Services (HFS) questions.

The Value of a Population-Specific Approach

The criminal justice system represents one of the largest catchment areas for people with untreated substance use disorders and mental health conditions, infectious diseases, and chronic medical conditions. This system can also be used to promote engagement in care. For example, problem identification and initial medical care often begin in a jail setting. Similarly, judicial leverage can be employed to engage people who are otherwise resistant to treatment in needed substance abuse and mental health services.

We believe the best business case for our approach is made by understanding the value of Medicaid expansion in the criminal justice system-related population. By enrolling our clients in CCOs where Federal matching funds are greatest, and by carefully managing their care and services, we can prevent their fall-out into more costly health care consumption, disability, and/or re-offending and incarceration.

Population Health Information. Compared to the general population, justice-involved populations have disproportionately high rates of chronic medical conditions (including diabetes, heart disease, asthma, HIV, etc.) (Binswanger 2009),¹ substance use disorders, serious mental illness, and co-occurring substance use and mental health disorders (Brecht 2004).² Like other chronic conditions, substance use and mental health disorders require ongoing, long-term treatment and management. Most people with these disorders need at least three months in treatment to stop or significantly curtail their use (NIDA 2006),³ and current research shows that attaining durable recovery typically involves multiple episodes of care over several years (Dennis 2004).⁴ The acute care treatment currently offered in jail and justice settings is insufficient to address chronic conditions. For those who receive it, treatment in incarcerated settings can begin the process of recovery, but continued services in the community are necessary for recovery to be sustained (NIDA 2006).⁵

The criminal justice population historically has very low rates of health insurance – 90 percent among jail detainees in one study (Wang 2008)⁶ – and no access, or interrupted access, to health care services and treatments. The continuity of care necessary to manage chronic conditions is unlikely to occur without oversight and coordination and access to adequate health care.

Over the past fifty years America's treatment of people with mental health and substance use disorders has evolved from the practice of hospitalizing them to institutionalizing them within prisons and jails. In 2009, the National Leadership Forum on Behavioral Health/Criminal Justice Services reported that on any given day, between 300,000 and 400,000 people with mental illnesses are incarcerated in jails and prisons across the United States, and more than 500,000 people with mental illnesses are under correctional control (parole and probation) in the community; drug law violators accounted for the largest percentage (MHA 2011).⁷

According to the Illinois Department of Corrections in its 2010 Annual Report, each year across Illinois, over 36,000 people are admitted and released from state prisons (IDOC

2010),⁸ and over 360,000 people pass through local jails (ICJIA 2009).⁹ In addition almost 100,000 individuals are on probation each year (Illinois Supreme Court 2009).¹⁰

This subpopulation has unique needs and requires more intensive or specialized services to be successfully integrated into routine health care. The following sections present an overview of the specific health characteristics of incarcerated individuals.

Mental Health

According to a recent report to Congress released by the National Commission on Correctional Health Care (NCCHC) and the National Institute on Justice (NIJ) on the health of soon-to-be-released inmates, a large proportion of inmates suffer from mental illness (NCCHC, 2002).¹¹ Prevalence estimates for specific mental disorders among state inmates were schizophrenia (2–4 percent), major depression (13–19 percent), bipolar disorder (2–5 percent), dysthymia (8–14 percent), anxiety disorder (22–30 percent), and posttraumatic stress disorder (6–12 percent). Similar rates of mental illness prevalence estimates were found for jail inmates: schizophrenia (1 percent), major depression (8–15 percent), bipolar disorder (1–3 percent), dysthymia (2–5 percent), anxiety disorder (14–20 percent), and posttraumatic stress disorder (4–9 percent) (Veysey & Bichler-Robertson, 1999).¹² These rates are 2 to 5 times higher than prevalence estimates of mental illness in the community (American Psychiatric Association, 1994).¹³

Substance Use Disorders

Drug and alcohol use disorders are nearly universal among people involved in the criminal justice system. In 2008, between 49 and 87 percent of arrestees tested positive for illicit drugs in one survey (ONDCCP, 2009).¹⁴ Two-thirds of jail detainees report using drugs regularly (James, 2004).¹⁵ Between 45 and 53 percent of prison inmates meet the clinical criteria for substance abuse or dependence, and more than half reported using drugs in the month before their arrest (Mumola, 2006).¹⁶ These conditions, which contribute to recurring criminal behavior, usually are untreated or inadequately treated.

Exceedingly high rates of relapse have also been reported; within 3 years, approximately 95 percent of state inmates with drug-use histories released to the community return to drug use. Recidivism for substance abusers is also very high, with 68 percent rearrested, 47 percent convicted of a new crime, and 25 percent sentenced to prison for a new crime (Langan & Levin, 2002).¹⁷ High recidivism rates are also related to violations of parole or conditional release, as more than one third of state prison commitments are violators (BJS, 2002).¹⁸ Studies have found that these violations are frequently related to drug use (relapse) (Cropsey, 2007).¹⁹

Medical Problems

Compared to the general population, justice-involved populations have disproportionately high rates of chronic medical conditions (including diabetes, heart disease, asthma, HIV,

etc.) (Binswanger 2009).²⁰ A 2004 Council of State Governments report noted that healthcare spending in state prisons grew 10 percent annually between 1998 and 2001. At the time of the study, medical care costs totaled \$3.7 billion annually and accounted for about 10 percent of correctional spending. (Pew Trust, 2008)²¹ Approximately 40 percent of newly incarcerated inmates reported a medical problem at intake despite the fact that 88 percent of inmates are younger than 50 years old. The most frequently reported medical problems included heart problems (1.1 percent), circulatory problems (2.4 percent), respiratory problems (1.4 percent), kidney and liver problems (0.9 percent), and diabetes (0.9 percent) (Maruschak & Beck, 2001).²² These medical problems can, in part, be attributed to various factors including the overwhelming majority of offenders (nearly 70–80 percent) who smoke, the higher prevalence of alcohol and illicit drug use and the lack of accessible preventative health care prior to incarceration. Offenders also have higher rates of infectious diseases such as HIV/AIDS, tuberculosis (TB), and hepatitis (Hammett, Harmon, & Rhodes, 2002).²³

HIV/AIDS, TB and Hepatitis

Many substance-abusing individuals who are at risk for incarceration also are at high risk for HIV/AIDS. Public health estimates are that 17-25 percent of individuals with HIV pass through the correctional system (Springer, 2005)²⁴ The rate of TB infection is 3.6 times higher among incarcerated people than in the general population (MacNeil, 2005)²⁵. Among the U.S. population, 1.6 percent is infected with the Hepatitis C virus (HCV). These rates are amplified among the offender population, with an estimated 31 percent of correctional populations infected with HCV.²⁶

Health Improvement Challenges and Opportunities. These data points, as well as our experience with the population, help to crystallize certain important characteristics of the population, as well as their problems and potential solutions that we summarize below. This high-risk population demonstrates:

- Multiple chronic conditions and thus a high risk for disability
- Untreated disorders that lead to criminal justice involvement
- The experience of being under-served and uninsured for socioeconomic and eligibility reasons (low-income males who are not disabled are currently ineligible for Medicaid in Illinois)
- Little if any education about how to use the health care system – few seek care at community health clinics even when they become ill, relying instead on high cost emergency room visits when the illness is exacerbated by lack of earlier intervention
- A great need for health promotion and health literacy education to prevent illness and improve health outcomes

*TASC Response to Request for Information
Coordinated Care Key Policy Issues*

- Complex social needs that require intensive case management and care coordination to ensure that care plans are developed with clients, understood and acted upon
- Substance use disorders and mental health conditions that are highly treatable – when appropriate treatment is accessed, the impact is very positive in this population
- Potential value in terms of diversion from expensive emergency room visits (a blight upon the Medicaid budget) and avoidance of re-offending and incarceration (critical concerns to the Department of Corrections and the Office of the Governor)

Criminal Justice-Involved Populations and Coordinated Care

Illinois has made substantial investments in building effective linkages between the criminal justice system and community substance use disorder and mental health treatment with the goals of decreasing incarceration and increasing public health and safety. We believe the State should build on this long-standing foundation through policy, financing and system development strategies during its expansion of Medicaid. As codified in the Medicaid Reform Legislation, this will necessarily include coordinated care.

The issues confronting criminal justice-involved individuals with mental health and substance use disorders as they intersect with managed care organizations vary widely from state to state and county to county. The laws and policies governing managed care, the methods employed by courts and correctional programs and the policies of Medicaid and managed care organizations, though similar, are never quite the same. There are, however, important principles underlying managed care successes and the prospects for coordinated care. The most important principle is that all parties have critical roles to play, and that they must support each other, understanding they have a shared stake in the performance of the system.

Targeted programs like those managed by TASC in Illinois will help CCOs achieve their goals by: improving success rates of treatment; reducing the over-use and misuse of costly services; reducing recidivism; monitoring the performance of treatment providers; encouraging the development of the most accountable and effective programs; and deploying staff to monitor clients' progress. CCOs can support the work of TASC and services for justice-involved clients by: expanding networks of providers to reach under-served communities and populations; identifying the treatment programs that are most effective; and expanding access to coverage by ensuring premiums are affordable.

TASC contends that there are significant opportunities for success in the following strategies:

- **Address the high risk of disability.** The Washington State Medicaid Agency (Department of Social and Health Services/Aging and Disability Services

Administration) has issued a report on its attempts to control costs and improve quality by analyzing the interactions between substance abusers in the Medicaid system and the subpopulation that is involved with the criminal justice system. Their study shows that untreated substance abuse is a key driver of chronic physical disease progression that results in qualification for disability related Medicaid coverage. Providing alcohol/drug treatment to those who require it slows disease progression. In addition the low state share of costs for the Medicaid expansion population creates a financial incentive to provide the treatment needed to lower disability rates and realize the concomitant cost savings. The long-run state share of costs for the expansion population will be approximately 10 percent, compared to 50 percent for SSI-related Medicaid coverage. Thus keeping clients healthy enough to remain enrolled in expansion coverage rather than SSI-related Medicaid will produce large state general fund savings. The proportions of these saving are large and are depicted in the chart below, which describes Washington State’s projections for their residents (Mancuso, 2010).²⁷

Illustration of potential General Fund-State savings from preventing transition to disability coverage

	YES. Receives Alcohol/Drug Treatment			NO. Does Not Receive Alcohol/Drug Treatment		
	Total Annual CD Treatment Cost	Total Annual Medical Cost	Total GF-S Expenditure	Total Annual CD Treatment Cost	Total Annual Medical Cost	Total GF-S Expenditure
2014	\$2,500	\$5,250	\$0	\$0	\$5,750	\$0
2015	\$2,500	\$5,513	\$0	\$0	\$6,613	\$0
2016	\$0	\$5,788	\$0	\$0	\$7,604	\$0
2017	\$0	\$6,078	\$304	\$0	\$8,745	\$4,373
2018	\$0	\$6,381	\$383	\$0	\$10,057	\$5,028
2019	\$0	\$6,700	\$469	\$0	\$11,565	\$5,783
2020	\$0	\$7,036	\$704	\$0	\$13,300	\$6,650
	<i>Cumulative GF-S expenditure</i>		<u>\$1,859</u>	<i>Cumulative GF-S expenditure</i>		<u>\$21,834</u>

- **Recognize the Importance of Behavioral Health Case Management in a Coordinated Care Organization.** Among the lessons learned with respect to patient centered medical homes and health homes around the country is that while primary care physicians are in very high demand, particularly in medically-underserved areas, they do not have sufficient time in their practices for many of the care coordination activities we are speaking to in this document. TASC believes that professional case managers fill an important role and function when co-located in primary care practices, hospitals, clinics, corrections facilities, and/or managed care organizations. In addition to expertise in the criminal justice system, our qualified behavioral health case managers have experience and expertise in substance use disorders, mental health and primary care services and are essential to the successful treatment and re-integration of this large population.

- **Provide Technical Assistance Regarding Medicaid and Coordinated Care for Substance Use Disorder Providers.** Administrators of the criminal justice system and substance abuse treatment providers need to understand how health care is delivered in the era of coordinated, accountable and managed care. Furthermore, many of our stakeholders would benefit from an improved understanding of Medicaid. CCOs, substance use disorder providers and the population served by TASC require direction, assistance and development with respect to Medicaid eligibility and enrollment in the criminal justice populations, Medicaid rules, scopes of service, scopes of practice, level of care guidelines for substance use disorder treatment, and billing and reimbursement practices.
- **Provide Medicaid and Coordinated Care Organizations with Information about Criminal Justice-Involved Populations and Substance Use Disorder Programs.** It will be as important to educate Medicaid, managed care, and coordinated care stakeholders about how criminal justice substance use disorder treatment programs work and what we have learned thus far about the most effective paths from addiction to recovery. Similarly, TASC recommends a review of the epidemiological and prevalence data to ensure a common understanding of the co-incidence and co-morbidity of substance use disorders and other chronic medical conditions such as heart disease and diabetes. For instance, one of the highest priorities for CCOs in Illinois will be adoption and implementation of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC-2R). Without ASAM PPC-2R, managing and coordinating entities run the risk of making treatment planning decisions based entirely upon the medical model without consideration for what is clinically appropriate given the complexity and expansive nature of substance use disorders. ASAM guidelines have been carefully developed and refined over the course of many years and are commonly accepted as the best possible measures by addiction medicine experts.
- **Improve Communication Between the Courts, Corrections, Treatment Providers and Coordinated Care Organizations.** The success of coordinated care for TASC's clients will depend in part on the attention devoted to developing new relationships, maintaining mutual respect, and recognizing the importance of communication on behalf of coordinated care goals and objectives. Without an experienced facilitator like TASC, the potential for cumbersome court proceedings and burdensome administrative processes to frustrate all parties and impede progress is high.

While health information exchange will facilitate communication and collaboration, professional collegiality is of paramount importance. If the courts reject participation in these processes the result will likely be an increase in incarceration and the attendant costs.

- **Analyze Outcomes Data.** CCOs need to collect and analyze data to identify the most effective treatment options managed by TASC and our providers. Results should be assessed for both health outcomes and corrections cost avoidance. Because coordinated care encourages more integrated treatment and service planning and by virtue of innovations in biomedical research, pharmaceuticals and evidence-based practices, we suggest that informatics efforts be dynamic, collaborative, organic and open-ended.
- **Educate Policymakers.** Criminal justice managers and treatment providers need to ensure that state Medicaid, coordinated care and corrections policymakers appreciate the value of both treatment and criminal justice programs. Effective alcohol and drug treatment reduces the costs of other health, corrections and safety net programs. The value proposition is clear and compelling and should be communicated as such.
- **Understand Utilization Patterns in Criminal Justice and Substance Use Disorder Populations.** It is critical that policymakers understand the cultural differences between populations and that, for example, criminal justice, mental health and substance use disorder clients generally do not engage the primary care or medical system in the same fashion as the general population for reasons related to stigma. Their preference for receiving primary care services in behavioral health settings is well documented and will need to be taken into consideration in the design of Illinois' CCOs.
- **Collaborate in the Development of Health Care Policy.** Managed care is evolving rapidly in response to Health Care Reform. TASC, the criminal justice system and our treatment providers are indispensable partners as the State of Illinois decides how to modify Medicaid, health insurance and managed care regulations. We suggest that there will be a great deal of innovation in the years to come and that all stakeholders will benefit from rapid cycles of change management.

Who is TASC Illinois – Background and Introduction

TASC is a not-for-profit organization that provides behavioral health recovery management services for individuals with substance abuse and mental health disorders that are engaged in the various parts of the criminal justice system in Illinois. Through a specialized system of clinical case management, TASC initiates and motivates positive behavior change and long-term recovery for individuals.

TASC is a state-mandated alternative to incarceration. It places and monitors thousands of nonviolent offenders in drug treatment programs across Illinois. Eligible offenders are mandated to TASC with community treatment and supervision as part of their probation sentence.

TASC provides significant cost savings for the State. It costs Illinois taxpayers \$24,899 annually to incarcerate a non-violent, drug-using offender. Alternatively, placing the same individual under TASC supervision as an alternative to incarceration and supplying community-based drug treatment through a TASC network provider costs the State less than \$5000, approximately one fifth of the cost of incarceration.

TASC programs also result in **safer communities**. For clients mandated to TASC as an alternative to incarceration, arrests for both drug crimes and property crimes were reduced by 71 percent due to their involvement with TASC. In addition, TASC's reentry case management services are core to the Illinois Department of Corrections' Sheridan and Southwest Illinois reentry programs. A year after release, Sheridan releasees had a 44 percent lower risk of returning to prison than those who did not receive treatment and TASC involvement.

Finally, TASC clients are **twice as successful in treatment** as other criminal justice clients in treatment. Two thirds of TASC criminal justice clients complete treatment successfully, compared to only one third of all criminal justice-referred clients in Illinois.

Mission-Driven. Since 1976, TASC has been offering life-changing opportunities for people whose substance abuse or mental health problems have put them at risk for chronic involvement with the justice system. We place people into rehabilitative programs across Illinois and provide monitoring and recovery support for sustained success. Through direct services and public policy, we advocate for effective and cost-saving solutions that allow individuals, families, and communities to thrive.

Highly Networked and Integrated. TASC works closely with a variety of state agencies, courts and judges, law enforcement, communities, housing and employment services, mental health and substance use disorder treatment providers, as well as primary care and other medical providers to manage and coordinate the care of our client population. We have a rich tradition of developing long-term and mutually reinforcing relationships and partnerships and understand that it is by bridging services and programs that we succeed in reintegrating our clients in their communities. We value and maintain a client-centric, comprehensive and long-term perspective while applying a systems dynamics model to our functions which helps us transcend organizational boundaries and navigate multiple, interdependent systems on behalf of our clients.

Reputation for Success. TASC is recognized as a solution-oriented and highly effective resource in Illinois. Since our incorporation in 1976, we have operated with cutting-edge clinical and care coordination principles and practices, continuously improving our performance for clients and demonstrating value through outcomes and other quality data. Our provider networks partner with us to produce significant savings by ensuring the criminal justice population receives the services it needs, where and when it needs them, and monitors services until people exit the criminal justice system, returning to their lives as family and community member and productive citizens.

Illinois-Specific. The State of Illinois has invested in the TASC infrastructure for more than thirty years. We are well-established in all of Illinois' 102 counties – rural, suburban and urban – and reflect the diversity of our State's people, cultures, ethnic groups, and minorities. TASC staff and our hundreds of network providers are multi-disciplinary and consist of experts in mental health, substance use disorders, primary care, case management, child welfare and adoption assistance services as well as the adult criminal justice system. TASC staff operate from more than 40 office locations statewide including primary offices and co-location sites. *(See attached map.)*

Focused on Coordination and Innovation. TASC staff and network providers bring to bear a long history of integration, co-location and collaboration between substance use disorder treatment, mental health treatment and primary care. On a daily basis, our staff work directly in the Illinois communities we serve, in the offices of our agency and provider partners, as well as in the homes and facilities in which our clients live and where many of our services are delivered. For example, we have significant experience with the *Screening, Brief Intervention and Referral to Treatment (SBIRT)* prevention model. We believe this capacity will lend itself well to Illinois' Coordinated Care Organizations. This and other models are replicable and can be "*transported*" across the state by TASC's Training and Technical Assistance teams who have proven their capacity to develop and "*spread*" innovations and best practices quickly. Moreover, TASC subject matter experts bring to bear valuable data, experience and infrastructure to provide consultation and innovative approaches that help bridge gaps between health care systems, programs and providers.

TASC Capabilities Statement

Core Services - TASC provides direct case management services, provides expert consultation, and helps design model programs that bridge and enhance public systems and community-based human services. TASC's purpose is to see that under-served populations gain access to the services they need for health and self-sufficiency, while also ensuring that public and private resources are used efficiently.

TASC case management services ensure that clients stay in treatment long enough to establish a foundation for durable recovery. Successful community reintegration requires an effective synthesis of treatment, community supports and rehabilitative services, and pro-social skills building. To that end, TASC services include the following elements:

- Provide court, jail and parole advocacy during pre- and post-incarceration phases;
- Conduct comprehensive assessments including substance abuse, mental health and medical care needs and collateral interviews;
- Develop service plans for, and place clients in, mental health and substance abuse treatment, medical care, housing and other needed services;
- Secure access to resources including public insurance and income support programs;
- Secure access to initial services prior to release from any institutional setting;

*TASC Response to Request for Information
Coordinated Care Key Policy Issues*

- Provide ongoing, intensive, outreach-oriented community-based case management to support engagement and retention in services, crisis planning and prevention and practical support, such as accessing disability benefits, housing and support for activities of daily living; and
- Assist clients in navigating complex public systems, advocate for their access to services, and support them in engagement and retention activities and in achieving wellness and self-sufficiency.

Case management at TASC is not a stand-alone service, but one aspect of a unified system to manage complex conditions. Case managers play a vital role in negotiating contact between the different service systems, and provide important linkages to public system referring agencies. TASC works with more than 200 agencies statewide that provide treatment for substance use and psychiatric disorders, as well as agencies that provide recovery supports, habilitative services, housing and those that help clients meet basic needs. Thus TASC works with partners to articulate priorities, establish clear direction on complex cases, and build systems integration.

Additional Services & Capabilities

- **Developing and Managing Provider Networks**
 - TASC excels at engaging the full continuum of mental health, substance use disorders, primary care, and social service providers required to treat the criminal justice and other high-risk populations
 - We validate network provider credentials and negotiate service agreements
 - We develop and manage full service networks throughout Illinois
 - We manage network data and identify gaps in systems and networks
 - We can provide internet-based systems that support electronic health information
- **Managing Outcomes**
 - TASC measures and analyzes service, financial, utilization, retention, and satisfaction data
 - We develop flexible systems that can accommodate access, effectiveness, efficiency, and specific outcomes and quality metrics
 - We detect and monitor treatment patterns, engagement and retention, and appeals
 - We develop data analysis and reporting capabilities on a program-specific basis
 - We develop, manage and refine processes that support continuous quality and performance improvement
- **Training, Technical Assistance (TA) and Building Capacity**

*TASC Response to Request for Information
Coordinated Care Key Policy Issues*

- TASC develops unique training and TA for our networks based on specific models, programs and goals including the integration of the operational and clinical gaps that exist between mental health, substance use disorders and primary care
- Examples of our TA and training include projects focusing on Compliance, Information Technology (IT), and Clinical Models and Associated Skill Sets
- **Developing Practice Guidelines and Service Protocols, Consulting and Development**
 - TASC conducts research and development, mines its data and evaluates programs and practices to discover the most effective approaches to treating our populations
 - TASC is equipped to identify under-served criminal justice-involved populations
 - We work cooperatively with payers and agencies to develop plans, budgets and protocols that reflect what we have learned from our experience and data

1. How comprehensive must coordinated care be?

- a. **Q: 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?**

A: Yes, we support the development of organizations that arrange care for the Medicaid population and the entire comprehensive set of services that the State envisions. Bringing together a core provider/manager such as a health home program, and requiring that entity to build and support the broad network of specialists on whom Medicaid recipients rely today is an essential yet challenging undertaking. The network of specialists would presumably include those that provide medically necessary care, such as mental health and substance abuse organizations, but also those that manage, coordinate and/or otherwise provide access to the a wide range of treatment and recovery support services, jobs, housing, education and other socially necessary resources.

At issue is whether Medicaid would require the entity to receive payment for and reimburse such specialists or continue to pay such entities directly but hold the primary entity responsible and at partial or entire risk for the total amount expended. Presumably, in either case, the primary entity would be responsible for ensuring data connections and real time flow of information between and among the parties so that all parties could track and study performance, process, utilization and outcomes in a transparent manner. We recommend that Medicaid continue to make such payments directly to specialists for at least several years so that the transformation to more detailed and refined specifications can occur in a stepwise fashion.

We strongly recommend that one of the required specialists be an organization that facilitates health and social services care for the individuals connected with the criminal justice system. These are all high risk individuals, whether they are individuals on probation or parole and preparing to leave a juvenile or adult correctional facility. Their health and social needs are profound and as we have identified in this introduction, the necessity of addressing them is increasingly well recognized. Failing to utilize the envisioned coordinated care system to address their reentry into society and stabilize the health of this population will inevitably result in ever higher medical, correctional and social costs over a lifetime.

Additionally, rapid enrollment for this population will greatly improve success. When members of our population leave facilities or enter the sentencing deferral, probation or parole system, they need to be engaged immediately so that assessment, diagnosis, treatment planning and care management take place right away. Failure to have plans in place results in individuals being lost to the system until they once again are brought to the attention of the health system or courts in a deteriorated condition

Several strategies can be pursued in conjunction with Medicaid and CCOs. One is establishing presumptive eligibility pending confirmation for people enrolling within jails and prisons, prior to release. An alternate option is to use fee-for-service payment for services during any waiting period for managed care enrollment. Yet still another alternative might involve developing the infrastructure to more rapidly process enrollment prior to release..

- b. Q: Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time, i.e. start with a base set of requirements and gradually increase over time?**

A: We encourage the Department to prioritize the award of contracts to those entities that are able to provide all elements and allow those that cannot do so immediately to identify ways to provide the base requirements, phasing in the remaining requirements within a two or three year period.

- c. Q: 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?**

A: Please see our response to question 1a above. We see the medical home as a comprehensive care organization accountable for meeting the majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. It will generally consist of a team of health professionals ranging from primary care physicians to nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. These teams may be large and diverse but will also incorporate virtual teams linking themselves and their patients to mental health and substance use disorder providers and services in their community, and include other specialists. We defer to the Department for whether to include NCQA certification requirements or the potential to use some or all of the CMS requirements for ACOs that they may publish.

Maximizing utilization of low-cost health services, including ongoing care for chronic conditions, is of great importance in improving health outcomes and minimizing costs. However, medical homes are not likely to initially attract the participation of this population without outreach and educational support. Lacking insurance coverage today, they are most likely to receive acute care in emergency rooms and jails. Generally they do not seek care at community clinics. We believe that health promotion and health literacy education will be needed broadly to encourage change in health care utilization among this population. We are prepared to employ novel strategies for outreach and education to enroll and secure care for members of this population.

- d. Q: 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?**

A: The department should be as explicit as possible, given that this is a new system of care. Very few individuals or organizations have experience operating in the new mode, and only on a partial basis. Thus most participants will have many questions.

With regard to the care coordinator role, we would expect that such functionality would be required for serving individuals with multiple chronic conditions and/or with high levels of need. Clearly, this is an essential service element for our population.

On the other extreme, much less care management will be required for those relatively more healthy recipients. However, we would expect virtually all recipients would benefit from some care coordination.

- e. Q: 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?**

A: The Department could potentially gain efficiencies by providing some types of umbrella coverage for all CCO entities, such as a master pharmaceutical contract or possibly an information systems development contract to facilitate communication and connectivity to the various systems currently operated by the many participants in a CCO. Our unique capacities to serve the participants of criminal justice system may also be an area where an umbrella or carve-out contract to serve all coordinated care entities would be a sensible option and provide efficiencies and better overall quality.

It should be noted, however, that as a general rule we are concerned that any such umbrella contract should be a later refinement, not one undertaken initially. This will allow the initial CCOs to foster innovation and creativity. It is both desirable and necessary to develop and test various types of CCOs and the assumptions behind their formation in order to find the better ways of operating.

In addition, using local and/or regional organizations, as opposed to a statewide entity, will help to ensure cultural sensitivity to communities and regions and minimize resistance to the transformational undertaking this coordinated care initiative represents. Once the various organizations are operational for several years, then Medicaid will have sufficient experience and data on which to base decisions about where crosscutting functions through an umbrella contract will produce meaningful results.

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

A: Four incentives that should stimulate the interest of a wide range of providers include 1) information systems and data management support, 2) technical assistance for startup and initial operations, 3) participating as a preferred provider and 4) the availability of upside financial performance opportunities.

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

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

A: We believe that the existing array of quality measures for the medical conditions of the Medicaid population are quite robust including those covering access to care, quality of care, member/patient satisfaction, and managed care accreditation. Furthermore, quality measures and initiatives stemming from the Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and URAC are essential to the long-term viability of accountable and coordinated care models, including the 65 quality measures in Medicare's recent ACO proposed regulations. We would expect that an effort to prioritize and integrate these measures for this program would prove effective in arriving at standards that are amenable to the public, providers, payers, and policy-makers alike. However, only a limited number of these measures are appropriate for TASC's distinct high-risk populations. We urge the State to consider the criminal justice-involved mental health and substance use disorder population approaches we have developed in Illinois and integrate and promote them across the coordinated care delivery system of the future. We recommend the adoption of the following behavioral health quality measures for the criminal justice populations we serve:

- **Follow-up and monitoring through entire episodes of care, particularly at each transition in care.** HEDIS Behavioral Health and National Quality Forum (NQF) measures recognize the importance of follow-up. Nowhere is follow-up and monitoring more important than among criminal justice clients who run the risk of relapse and recidivism if and when their care is not continuously coordinated and managed.
- **Institutional and process performance where eligibility, enrollment in coverage, and engagement in treatment are concerned.** Immediate enrollment and immediate engagement – measured in hours and days as opposed to weeks and months - are vital to the success and health prospects of this population. Without immediate engagement in service plans and navigation through the system of care, this population is highly susceptible to overdose, recidivism, and early death upon release. We strongly recommend that the State facilitate immediate enrollment through one of the options described in our response to Question 1(a). **Access to a robust**

network of qualified behavioral health and medical providers and the necessary range of services. Access to evening and weekend hours are also of critical importance to criminal justice and other high-risk populations. Access is also a measure of reasonable case load rates among case managers and other treatment providers, underscoring the importance of adequate numbers of providers. Access to qualified behavioral health care coordinators with experience and expertise in the criminal justice system is also critically important.

- **Retention throughout episodes of treatment and adherence to treatment and service plans** are keys to the success of the criminal justice involved behavioral health client. Retention and monitoring of care is especially important at transitions in care and between professionals.
- **Fidelity to evidence-based practices and practice guidelines** is important and complex where the medical, behavioral health, social and rehabilitative needs of the criminal justice population are concerned. This is a considerable challenge where the high incidence of multiple chronic conditions exists.
- **Patient Satisfaction/Dissatisfaction** is vital to the measure of success or failure in quality management initiatives. The criminal justice population represents a unique challenge in that our clients are often struggling against multiple forms of stigma reflecting their criminal justice system involvement as well as their mental health and/or substance use disorders. To the extent that this population is stigmatized and becomes disaffected, compliance with treatment suffers and the risk of costly crisis care and recidivism rises.
- **Quality of Life measures.** Quality in the criminal justice population we serve is measured in large part by several key quality of life indicators including: reduction in use, mental health symptom stability, establishing safe shelter/housing, community integration, employability and employment, education, family reunification and avoidance of future arrests.

b. Q: 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?

A: TASC firmly believes that the State should maintain different measures for populations with unique or special attributes. In our case, our rich history of providing care management services to the criminal justice-involved mental health and substance use disorders populations has reinforced our position. Our answer to question 2a above illustrates the types of measures we would propose be established for this and other high-risk populations.

c. Q: 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?

A: In the case of TASC and the criminal justice-involved mental health and substance use disorders populations we serve, client risk adjustment is fully expected to remain high relative to the general population. We frankly do not expect to *level the playing field*. Rather, we believe the solution involves highly specialized care coordination that strives to meet high-risk needs with appropriate services. In the process, TASC's activities alleviate unnecessary burdens in other areas throughout the health care system (emergency departments, for instance) achieving crucial efficiency and cost-effectiveness objectives.

d. Q: 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?

A: TASC's position on this matter is that organizations such as CMS, the NCQA and URAC can come to consensus with the broad medical community on a reasonable number of quality measures for the broad needs of the general population. We also believe that chronic conditions and high-risk populations require heightened levels of attention, collaboration and additional time and resources where implementation is concerned. As has been discussed in this section, the criminal justice-involved mental health and substance use disorders populations' quality and outcomes should be measured using a blend of conventional methods such as HEDIS and population-specific measures that ensure special needs are being met. We have provided the following references to widely accepted guidance on the matter:

Recovery-oriented system of care (ROSC), SAMHSA's outcomes measures
http://www.pfr.samhsa.gov/docs/Guiding_Principles_Whitepaper.pdf

NIDA's 2006 Principles of Effective Treatment for Criminal Justice Populations
http://www.nida.nih.gov/podat_cj/

SAMHSA's 2005 Treatment Improvement Protocol 44: Substance Abuse Treatment for Adults in the Criminal Justice System
<http://www.ncbi.nlm.nih.gov/books/NBK14168/>

SAMHSA's National GAINS Center, in coordination with the Center for Mental Health Services (CMHS), has identified six evidence-based practices for mental health treatments with potential for application in criminal justice settings
<http://www.gainscenter.samhsa.gov/html/ebps/default.asp>

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

A: Neither TASC nor the State are sufficiently experienced with pay-for-performance models where behavioral health treatment and care coordination for the criminal justice-involved mental health and substance use disorders populations are concerned. We therefore suggest that the State and TASC take an incremental approach that allows the entire system – particularly the providers of treatment

services – to gradually become more accountable for quality. The State must preserve much of the system of care it has developed over the past thirty years. The State is urged to exercise caution in the initial implementation of reforms to avoid disqualifying a large share of providers who, due to capacity reason, are at a disadvantage reporting collecting and reporting quality measures. We recommend a graduated approach to pay-for-performance or performance-based contracting wherein a 3 percent incentive would apply in the first contract year followed by consecutive increases of 1 percent every year for the next two years. At the conclusion of the third year, the State might introduce withholds on the same graduated timeline whereby providers would eventually be penalized for poor quality scores.

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

A: We recommend that the Department convene a series of meeting to include but not be limited to managed care organizations, self-insured employers, relevant subject matter experts from the NCQA, HEDIS, HHS, and AHRQ, the provider community, research universities, and patient advocacy groups. In addition to establishing a strategic plan, goals and objectives, the Department is advised to broker the formation of a multi-disciplinary and multi-stakeholder committee for the purpose of establishing a uniform set of standards, acknowledging that the vision is long-term. We believe this is a work in progress and that the process should be incremental, learning from pilot and demonstration projects, analyzing and interpreting data, and making adjustments in rapid cycles of change and improvement. TASC recommends that the Department leverage the Governor’s Health Care Reform Implementation Council and take advantage of its efforts to establish quality measures.

g. Q: How will we know when we have achieved care coordination, i.e. how should we measure success?

A: We propose that the Department first recognize the distinctiveness of *Care Coordination* where the behavioral health needs of the criminal justice-involved mental health and substance use disorders populations are in question. TASC believes that a clear definition of this and other terms is an important next step in this process if we are to reach consensus in terms of defining and measuring success. In the case of criminal justice-involved substance use disorders, success will be a measure of increased access to low-cost care and services and the removal of institutional and bureaucratic barriers as well as the most efficient use of blended funding. Having achieved that impact, we are confident that we will have witnessed the success of a shared vision for the “Any Door” approach and that enrollment efforts will have succeeded; direct linkages between services and providers are a success; and that initial engagement in treatment planning was and is successful.

Our care coordination includes a very wide range of mental health, substance use disorder, medical, social, housing, rehabilitation, vocational, educational and criminal justice activities (interfacing with probation and parole, for example). We would propose that a unique definition and constellation of services be identified for this and other high-risk populations in order to preserve the *Safety Net* features of the system that are so important to the success of this population.

We also submit that this definition of Care Coordination begins within the criminal justice system itself. The success or failure of our clients depends largely on their engagement while they are still in the system, pre-release enrollment and engagement, and involvement in service and treatment planning prior to their discharge into the community.

Ultimately, success will also be a function of accomplishing the goals we establish for ourselves among the assortment of measures we identified in section 2 (a) above.

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

- a. **Q; 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: TASC is dedicated to the adoption of electronic health information systems and the appropriate communication and exchange of health information. However, whether or not electronic medical records and health information exchange are commonplace, the treatment of substance use disorders is bound by Federal law protecting the confidentiality of our patients. In the early 1970's, Congress recognized that the stigma associated with substance abuse and fear of prosecution deterred people from entering treatment and enacted legislation that gave patients a right to confidentiality. For the almost three decades since the Federal confidentiality regulations (42 CFR Part 2 or Part 2) were issued, confidentiality has been a cornerstone practice for substance abuse treatment programs across the country.

In 2000, the Department of Health and Human Services (HHS) issued the "Standards for Privacy of Individually Identifiable Health Information" final rule (Privacy Rule), pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, Subparts A and E. Substance abuse treatment programs that are subject to HIPAA must comply with the Privacy Rule. Part 2 protects any and all information that could reasonably be used to identify an individual and requires

that disclosures be limited to the information necessary to carry out the purpose of the disclosure. See 42 CFR §§2.11 and 2.13(a).

We recommend a careful review of the law and position papers prepared by organizations such as the Legal Action Center (LAC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) for opinion and interpretation of the rules concerning the exchange of health information relative to substance use disorders.

That said, we recognize the over-arching importance of coordinating care between substance use disorder, mental health and primary care and have a long history of effective communication between all three stakeholders in the State of Illinois where the criminal justice-involved mental health and substance use disorders populations is concerned. We have established policies and processes which assure that all communication conducted in the interest of our case management and care coordination efforts is in full compliance with Federal privacy and confidentiality laws. We suggest building upon our successful approach and methods.

TASC fully supports communication relative to service planning and the coordination of care between providers. Our strict policy is to abide by Federal law and - assuming the release of information supports the medical, behavioral health and social goals of our client - we facilitate communication. TASC is capable of exchanging administrative, clinical and demographic information.

TASC is a leader in the development of electronic records specific to the care coordination of the criminal justice-involved mental health and substance use disorders populations. We propose evaluating the prospective interface of our proprietary Internet-Based Technology Systems that allow centralized data processing and easy, real-time access to clinical and fiscal data. We expect that our statewide system can be interfaced to facilitate the exchange of health information with coordinated care organizations.

b. Q: Should the Department offer bonuses for investments in EHR systems, above the substantial incentives from ARRA?

A: Yes. The substance use disorders treatment field is unique among its mental health and primary care counterparts in having few Eligible Providers (MDs and Nurse Practitioners) in our ranks. Eligible Providers (EPs) are the only providers who might qualify for incentives should they *adopt, implement or upgrade* their *certified* EMR systems.

While we strongly support the development of a robust IT infrastructure in Illinois and the *Meaningful Use* of health information (within the confines of 42 CFR where our information is concerned), we do not expect that the current ARRA incentives will provide very much financial motivation or relief in our field. We urge the State, providers, and the health care foundation stakeholders in Illinois to collaborate in

the development of health IT investment, grants and incentives for this field. Without targeted investment, grants and incentives, these providers will be at a considerable disadvantage, thwarting efforts to truly integrate all health information in a standardized fashion and thus compromising the true coordination of care in upwards of 80 percent of the highest risk multiple chronic conditions cases.

It is also the case that EPs must already be Medicare and/or Medicaid providers receiving a substantial portion of their reimbursements from either payer. Many of the State's substance abuse treatment providers do not meet thresholds established by ARRA HITECH Act for Medicaid and/or Medicare incentives. Further, many behavioral health information systems and vendors only recently received or applied for Office of the National Coordinator of Health IT (ONCHIT) certification and have lagged behind medical EMR vendors. Lastly, Continuity of Care Documents and Records (CCD and CCR) have traditionally been designed and developed to suit medical specifications, thereby requiring a focused effort to integrate behavioral health information and the unique needs of the criminal justice populations.

- c. **Q: 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?)**

A: Most of our providers have limited operational interface with Medicaid, instead billing through the Illinois Division of Alcoholism and Substance Abuse (DASA). In addition, the majority of their clients are not eligible for or not yet enrolled in Medicaid. Many providers actually bill Medicaid on paper, but very few bills are paid and collections are problematic. Their care and services are funded by other programs and agencies such as the Illinois Department of Correction and DASA. However, this trend will reverse in the near future – effecting a true paradigm shift in the way our providers and clients provide and receive coverage and care. TASC providers have adapted to very low-margin non-profit and grassroots business conditions and generally do not have the financing required to adopt and implement health IT. Additionally, TASC providers will begin with a very steep learning curve and will require technical assistance and training.

Given these conditions, incentives are absolutely critical in the immediate present and more so in the future. Financial support would have to come from other sources including the State and Illinois' health care foundations.

With respect to incentives, we support the notion that pay-for-performance incentives be incremental and believe this approach would enable IT incentives and implementation between 2012 and 2015.

- d. **Q: 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?**

A: *Meaningful Use* requirements are important and central to this effort; however, they are not sufficient. Again, ARRA HITECH incentives will not accrue to substance use disorder treatment providers at the same rate they do and will for primary medical providers, leaving TASC's substance use disorder providers at a distinct disadvantage. While financial support is critical to this effort, we recognize that our providers must also be held accountable to a contractual requirement that they have *adopted, implemented or upgraded* to a certified EMR before December 31, 2015.

We suggest that substance use disorder and mental health providers receive targeted Technical Assistance to accelerate proficiency in the wide range of health IT adoption and implementation activities. The State, providers and Illinois health care foundations must invest in ensuring that this specialized field is included and integrated into the vision for a health information network and Meaningful Use of health information – both of which are keys to coordinated care.

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

- a. **Q: How much risk should be necessary to qualify as risk-based?**

A: We believe that putting at risk as little as 2 to 3 percent of care costs should provide a sufficient basis to inject risk into a contract. However, as an organization operating today almost exclusively with governmental and non-profit grant and contract income as opposed to fee-for-service, administrative-service-only, or capitation-based income from insurers, we have limited experience in this area. Nonetheless, we are experienced with performance based contracts, as they comprise a significant portion of our income.

- b. **Q: 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?**

A: Yes. We believe both models are risk-based in that the participants are at-risk for the amount of the bonus or savings, which is triggered only by good or better performance. The "skin in the game" is the amount of the bonus. Depending on the size of that bonus, there can be either a large amount at-risk or a small amount. The prospect of forfeiting the payment of a large bonus can be a significant motivator, and the actual loss of the bonus for bad performance can be punishing.

Please note that there are also pay-for-performance contract models that are only downside risk-based. Accordingly, the basis for the contract is the cost of doing business, with or without some margin. Good or better performance triggers no bonus, but poor performance does trigger a penalty.

c. Q: If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?

A: We would participate in a longer term, two-sided pay-for-performance contract in which a bonus is paid based on performance at or above stipulated output or outcome measures and a penalty is withheld for performance below the stipulated measures. A pay-for-performance financial arrangement containing upside risk for a minimum of one and preferably a two year period, to be followed by balanced up-side and down-side risk corridors going forward, is an acceptable arrangement. It allows for time to establish adequate infrastructure capacity and good operating principles and practices. A critical component of any such contract, however, is the establishment of clearly defined and appropriate measure(s) of output or outcome.

d. Q: 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?

A: TASC is not a *coordinated care organization* by definition (i.e., we do not provide the majority of health services to individuals, but only a specialized set of services consisting of substance use disorder services to those associated with the justice system). We would prefer to participate with coordinated care organizations that operate in a *shared savings* business model. We feel strongly that the motivation under a full risk model is to constrain costs and care unnecessarily, adversely impacting quality and outcomes.

e. Q: 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?

A: We believe the shared savings bonus provisions and the medical loss ration (MLR) provisions defined by the Centers for Medicaid and Medicare Services in their recent Notice of Proposed Rulemaking for Accountable Care Organizations offers a reasonable basis on which to establish policy for Coordinated Care. We also suggest the Department consider the recently published study by the Commonwealth Fund, "*Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide*". The study examined how publicly traded health plans differ from non–publicly traded organizations in terms of administrative expenses, quality of care, and financial stability and found that publicly traded plans focused primarily on Medicaid enrollees paid out the lowest percentage of their Medicaid premium revenues in medical expenses and reported the highest percentage in administrative expenses across different types of health plans. The publicly traded plans also received lower scores for quality-of-care measures related to preventive

care, treatment of chronic conditions, members' access to care, and customer service.

f. Q: 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?

A: It is reasonable for the coordinated care entity to accept risk. We also believe it is reasonable for direct providers to accept some portion of risk, but much less than the coordinated care entity. As noted above, that risk might well be incorporated in an approach such as a pay-for-performance bonus/penalty. The amount of the bonus/penalty might be in some proportion to the amount of risk the coordinated care organization is assuming.

With regard to the basis on which risk is calculated, we are concerned with the relative amount of the substance abuse portion of the health risk. Recently, substance abuse treatment has received "parity" status with other health disorders under both state and federal law. The historical health data on the basis of which the Department will be developing its coordinated care financing model, however, does not yet reflect the contemporary, increasing and more appropriate utilization of substance use disorder services that parity is triggering. Thus substance use disorder services are at risk of being under-funded going forward.

Still further, because our focus is on those individuals associated with the justice system, where we have grossly inadequate data on the health care utilization of the population, the Department is likely to build a cost model further diminishing the actual experience and need for health care services.

g. Q: How should risk adjustment be included in the model? Conversely, how should "stop loss" or "reinsurance" programs be incorporated?

A: No comment

h. Q: 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?

A: To the extent that payments to the coordinated care entity can be tied to the actual health conditions and prior health utilization experience (perhaps for the last three years) of individual recipients enrolled with the coordinated care entity, the adverse selection risk is diminished appreciably. We recognize that accomplishing this is no simple matter. We also recognize and appreciate the importance of simultaneously and equitably tying risk-based payments to the *Triple Aims* of per capita cost, experience of care, and population health.

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

- a. **Q: 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?**

A: We expect that Medicaid will need to lead the market to a certain degree, as CCOs of the types envisioned are new entities and effecting change requires risk. However, we also recommend that the networks of organizations that ultimately comprise the CCO are individually experienced and financially healthy so that they contribute to the CCO entity either as a direct participant in the core organization or a specialty subcontractor. It would be desirable to select organizations that have proven care models and history of operating performance.

- b. **Q: 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?**

A: We defer to Medicaid and its expertise on this issue. We do not believe individual organizations that are specialist subcontractors to a CCO should be required to have Department Of Insurance certification, though they should have significant operating histories serving recognized governmental and public sector clients and demonstrated financial health.

- c. **Q: 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?**

A: Yes, there should be a minimum number of enrollees, while at the same time setting a threshold that enables a reasonably large number of organizations to participate. We would expect those serving higher risk populations would not need to have as many enrollees as those serving lower risk populations.

- d. **Q: 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?**

A: Recipients participating in CCOs should have access to specialty care for a comprehensive range of services including services targeted to those with current or recent involvement with the justice system.

- e. **Q: Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?**

A: Yes, if necessary to achieve Medicaid’s vision for coordinated care. However, because an organization serves expensive or difficult clients does not mean that the organization cannot perform according to standard operating principles expected by national standard setting organizations in their field. Stated differently, providing special arrangements does not equate to allowing an organization to underperform.

TASC believes that the criminal justice-involved substance use disorder clients differ from other substance use disorder clients in that they need especially strong emphasis on the following:

- More intensive case management that keeps them engaged in care for their co-occurring substance use, mental health and physical disorders.
- Service plans that address their practical life challenges and problem-solving skills in order to reduce barriers to their participation in treatment and recovery.
- Substance use, mental health and medical treatment that is of sufficient duration and intensity to stabilize their health and build greater capacity for self-care.

A consequence of the aforementioned special needs requires consideration of an incrementally greater reimbursement accommodation for providing these more intensive services.

6. What should be the requirements for client assignment?

- a. **Q: 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?**

A: We recommend preserving client choice to the extent it is possible. One way of doing so is to ensure that within each CCO or service area a comprehensive and sufficiently populated network exists. By so doing, clients have opportunities to select from among a number of providers for any given type of service. Specialist provider types such as behavioral health clinicians would be available to all members of the CCO, whether or not a member’s only health issue was a behavioral health matter or whether it was associated with another health issue. Requiring such a way of operating is both a practical, familiar and efficient way to operate.

Under the Medicare Notice of Proposed Rulemaking (NPRM) for ACOs, members have even greater choice of both primary care providers and specialists. They can choose to see any provider contracted with Medicare.

For those members newly joining a CCO program who have been seeing a provider not currently contracted or engaged as part of the CCO network, the member could continue care with “out-of-network” providers. The CCO would be required to offer the provider a “single case agreement” to sustain continuity.

- b. Q: 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?**

A: Ideally, providers would have coverage available on a statewide basis but be organized locally. As a specialist, we offer such coverage for most of our services. We are the only agency providing substance abuse assessments and recommendations for the Illinois courts statewide. As such, we are in a position to be of service to CCOs serving both major areas and neighborhoods.

- c. Q: 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)?**

A: Entities should be able to limit the population they service and the services they provide based on their expertise and record of performance with particular populations. However, entities should not be allowed to select recipients in some fashion that would create an adverse selection risk in the larger risk pool. Reimbursement must be equivalent to the degree of risk with the particular population.

- d. Q: On what basis should assignment of clients who have not self-assigned be made in the first year?**

A: We believe that the most reasonable way of doing so is by geography. To the extent multiple CCOs are available within one specific area clients should be assigned equally and on an alternating basis to each of the CCOs.

For a wide variety of reasons we have cited earlier, particularly in the Introduction section, the population we serve will require outreach and highly proactive engagement once they are assigned to a CCO. Only by doing so will they come to utilize and benefit from the services offered.

- e. Q: 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?**

A: We agree that these are both reasonable choices. However, the first would favor ACOs with greater brand recognition and better marketing capabilities (as opposed

to higher quality services), a larger network or the participation of a greater number of academic medical centers. The second would favor those with lower rates, without consideration to other factors. An alternative approach would be to assign based on geography, assuming that such a basis would result in greater convenience for the member. Yet another approach would combine all three factors in some proportion.

- f. **Q: 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?**

A: We believe three years of experience would be required to obtain the necessary information in a reliable fashion.

- g. **Q: 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?**

A: No response.

- h. **Q: If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?**

A: We do not have a recommendation, other than to support fully the concept of demonstrations in advance of full scale implementation. Particularly for the justice-involved population, very little data on their health care utilization is available. We would welcome the opportunity to participate in a demonstration that would provide data for research and program planning purposes.

- i. **Q: How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?**

A: As we have very few dual eligibles in our population, we have no comment.

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

- a. **Q: 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 whom Medicaid is their only coordinated care contact.)**

A: TASC understands the nature of this challenge and concern throughout the State of Illinois and has faced it in managing substance use disorder treatment for the

criminal justice-involved mental health and substance use disorder populations for more than thirty years. We believe that while the Department cannot absolutely ensure continuity in a free market, it can take strategic and tactical steps to ensure that behavioral health providers remain viable and that our programs remain sustainable. We suggest there are several critical elements required to ensure the continuity and viability of the substance use disorder prevention and treatment providers – particularly where the criminal justice population is concerned:

- Maintenance and enhancement of the current substance use disorder treatment system for the criminal justice population
- Integrated funding (also known as *blending* and *braiding*)
- Integrated programming and the inclusion of substance use disorder providers currently serving this and other populations
- Technical Assistance and infrastructure capacity-building support
- Requiring diverse contracts and funding
- Ensuring integration across Medicaid and the Health Insurance Exchange
- Mandating Reimbursement for Case Management
- Coordinating with the Department of Alcoholism and Substance Abuse for non-Medicaid services and for policy development based on population-specific expertise

Each of these strategies is explored further in the section below.

- b. **Q: 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 percent of the Federal Poverty Level)?**

A: TASC strongly recommends that the continuity of coverage and care issues be addressed by the Department as soon as possible. The criminal justice-involved substance use disorder populations experience significant and frequent changes in employment and income, increasing the likelihood that they will cross the threshold between subsidized health insurance available through the exchange and Medicaid eligibility. It is also common for these populations to experience lapses in Medicaid recertification. To the extent that gaps in coverage and care appear, these populations will experience higher rates of disengagement from treatment and potentially higher rates of recidivism and incarceration. TASC therefore suggests the following expanded strategies with respect to the continuity of coverage and care for our criminal justice-involved substance use disorder populations:

- **Ensuring Integration.** The Department and the State – perhaps in cooperation with the Insurance Commissioner – should encourage substance use disorder provider network alignment and consistency between Medicaid, CCOs, and plans participating in the Health Insurance Exchange. We believe that our high-risk populations – whether insured by Medicaid, enrolled in a Coordinated Care Organization, or members in an Illinois commercial health plan - should be interfacing with TASC for care coordination and health system navigation.
- **Mandating Reimbursement for Case Management.** Substance use disorders are chronic conditions that require TASC support over a long-term course of treatment and service planning. We strongly recommend that the State require coverage and reimbursement for case management and care coordination in the Health Insurance Exchange in order to ensure that the criminal justice populations and other high need chronic disease populations do not lose access to and coverage for our services if and when they become insured by the Exchange. Our case management functions will ideally transcend payers and support clients until they exit the criminal justice system.
- **Maintenance and enhancement of the current substance use disorder treatment system for the criminal justice population.** TASC believes that our infrastructure, network, hard-won experience, and highly-specialized case management expertise have been a very positive investment for the State of Illinois since 1976. Maintaining and expanding our role in a Coordinated Care Organizational structure will prove to ensure the State a return on its investments and is a critical component in a high-risk, high-needs and high-touch population fast-approaching Medicaid eligibility under Health Care Reform.
- **Integrated funding (also known as *braiding*).** We view the financing of substance use disorders, social services, mental health treatment, and primary medical care for the wide variety of criminal justice populations as having suffered considerable fragmentation. Therefore, we suggest that the Department and the State review and consider the suitability of integrated funding in order to optimize existing community assets and resources while adapting to a new Medicaid, health insurance and Mental Health/Substance Abuse Block Grants paradigm. The providers of substance use disorder treatment and prevention would benefit – as would the State – from the sustainability of blended funding, vastly improving the odds of continuity of care throughout the state.
- **Integrated programming and the inclusion of substance use disorder providers currently serving this and other populations.** The State is urged to evaluate the appropriateness of blending and integrating

programs that currently exist. The judicial (courts) system, family and children's services (child welfare), corrections, juvenile justice and public health system currently fund and provide services where providers and populations overlap a great deal. Integrated agency management, policies, processes, and programs would create significant efficiencies and lead to a much more stable business environment for our providers.

- **Technical Assistance and infrastructure capacity-building support.** TASC suggests that the State support a robust behavioral health provider Technical Assistance effort designed to help our providers - generally inexperienced with Medicaid and commercial health insurance/managed care - bridge the gap between paradigms and business models. In particular, our providers will require recognition as state-licensed providers, assistance with Medicaid and third-party billing processes, and financial support for the implementation of certified health information systems. Without this level of support, many of our providers will be a disadvantage in remaining viable and continuity of care will suffer.
- **Requiring Diverse Contracts and Funding.** TASC's participating substance use disorder treatment providers can agree to an incremental demonstration wherein they are marketing to and contracting with other payers over the course of the implementation. We would concur that the Department not remain their only coordinated care organization payer and that true sustainability is the product of diversified funding streams.

As for a *Basic Health Plan*, we expect that the CMS definition of *Essential Benefits* and the State's implementation of the 2008 *Mental Health Parity and Addiction Equity Act (MHPAEA)* will ensure continuity for our low-income criminal justice populations as they become insured by Medicaid and/or commercial health plans through the Exchange. We look forward to reviewing the CMS definition of *essential* mental health and substance use disorders coverage and treatment when it becomes available.

- c. **Q: 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?**

A: Yes, we believe they should and have attempted to capture the tactical measures the State can take in the question above.

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

A: Clients should retain all assumed rights of choice though we would expect that each medical home is appropriately qualified.

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

A: TASC believes there are a number of ways to collect de-identified information about plan quality. Where individual clients are concerned, regular patient satisfaction measures are instrumental. As for individually-identifiable information concerning quality, we adhere to HIPAA and 42 CFR Part 2 privacy and confidentiality requirements discussed in the health information technology section of our written comments. Any personally identifiable information will require signed disclosure and release of information where participation in substance use disorder treatment is concerned. TASC routinely and legally shares information using these protocols.

As for rights to appeal adverse utilization review and claims processing decisions, TASC supports the Appeals requirements in the *Mental Health Parity and Addiction Equity Act* which gives patients and providers the right to request medical necessity guidelines and a clear statement of justification from payers and managed care organizations. We also support the Appeals and *External Review* requirements of the *Affordable Care Act* wherein our patients and providers can request an external review in cases of adverse determination, necessitating that managed care and health plans submit contentious decisions to an unbiased ombudsmen panel of peers and experts in the community.

Finally, our clients experience service extrusion, e.g., being prematurely excluded from continuing participation. They will need case management advocates to help maintain eligibility, enrollment and participation in all necessary care and to access the appeals process when appropriate

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

a. Q: 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?

A: TASC is prepared to participate in coordinated care in a number of ways. TASC proposes to contract directly with CCOs:

- 1) To enroll eligible residents who are involved in the criminal justice system in Medicaid and CCOs;
- 2) To screen, assess, develop care plans and make referrals to appropriate panel providers;

- 3) To assure participation in low-cost community-based substance use disorder, mental health and medical treatment through office-based and mobile case management services, including ongoing monitoring;
- 4) To provide network development and management of a specialized and appropriately qualified network, drawing wherever possible upon those existing mental health and substance use providers used by the CCOs that express interest and experience with this population, and;
- 5) To provide ongoing consultation, training and technical assistance to stakeholders where criminal justice-involved substance use disorders and mental health care models, quality improvement and information systems implementation, as well as data analysis and reporting are concerned.

TASC proposes to contract with CCOs on a pay-for-performance basis with incremental implementation of performance-based incentives. TASC is also prepared to consider entering into shared-risk and reward financial models at such time as terms and conditions can be fully specified and TASC has accumulated the necessary reserves which will inevitably be required. TASC does not presently have sufficient reserves for this higher level of risk though we expect that the first three to five years of implementation will allow us to build capital.

- b. Q: 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.**

A: TASC is proposing a model that is proven to meet the needs of the criminal justice-involved mental health and substance use disorders populations and one that we expect will readily meet the needs of Medicaid recipients and the goals of Health Care Reform in Illinois. At its core is the Case Management Society of America's definition of case management: *"a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human services needs. It is characterized by advocacy, communication, and resource management, and promotes quality and cost-effective interventions and outcomes."*

Our model aggressively addresses the issue of care coordination described in the Institute of Medicine's (IOM) 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. The IOM report focused on delivery system deficiencies such as lack of coordination across the many elements of the delivery system, fragmentation that slows care and undermines personal accountability, poor communication and very limited use of information technology, and failure of health professionals to work together to ensure that care is appropriate, timely and safe. Nowhere is this problem more acute and costly than in the criminal justice populations. In addition, our model incorporates the National Quality Forum's description of Care Coordination as a function which *"helps ensure a patient's needs*

and preferences for care are understood and that those needs and preferences are shared between providers, patients and families as a patient moves from one healthcare setting to another. Care coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.”

The TASC model consists of the following elements and characteristics:

Business and Clinical Models – TASC is anticipating that it will be modifying its approach to incorporate the many elements of the Accountable Care Organization and Coordinated Care Organization models as well as the Patient-Centered Medical Home and Health Home models. All of these models feature very consistent approaches to structure and governance, collaboration and communication, integration and performance management.

We believe the best business case for our approach is made by understanding the value of Medicaid expansion in the criminal justice system related population. By enrolling our clients in CCOs where Federal matching funds are greatest, and by carefully managing their care and services, we can prevent their fall-out into more costly health care consumption, disability, and/or re-offending and incarceration.

Scalable Services - Our model builds upon our 30 years’ experience providing case management to the criminal justice population and other high-risk populations in Illinois. In addition to the centrality of case management, several other elements of our model add value to Illinois’ coordinated care program goals and objectives, including:

- client engagement and retention
- provider network management
- utilization management
- disease management
- population health management

Provider Networks - TASC has developed a highly scalable infrastructure and roster of behavioral health and primary care partners and has experienced and qualified staff in each of these progressive domains. Our current model and infrastructure reaches all of Illinois’ 102 counties and can readily add clients from a number of eligible high-risk populations. We believe that the CCO design will encounter high levels of demand in response to expanded Medicaid that will include people involved in the criminal justice system. Thus it will be important to continue to build adequate access and ensure choice statewide. Furthermore, TASC is capable of negotiating positive terms, conditions and reimbursement schedules with all of our providers and believe this may benefit our approach to CCOs as well.

Enrollment and Engagement - Engaging and retaining the criminal justice-involved mental health and substance use disorder participants in their own care requires organizational immediacy and focus. Our model presupposes that our staff can and will perform in a context that seeks to accelerate enrollment of our clients prior to their release. Once a client is enrolled and is assessed as having justice system involvement, that client should be engaged in care planning as soon as possible. We also seek to build the *motivation for change* in all of our clients as it is crucial to their success, though it is a skill that few have been taught or seen modeled prior to their involvement with our staff. Each of our clients' "next action steps" must be carefully defined and scheduled as efficiently as possible. Failure to do so increases rates of non-compliance and drop-out or "fall out," exacerbating the State's budget dilemma and decreasing overall quality of life. Ensuring that this practice is applied in a universal fashion contributes greatly to client retention and the success of interventions. Our aim is to return each client to full health, productivity and citizenship and our approach assures success with early enrollment and long-term engagement.

Integrated and Co-Located Case Managers - How the provider network is engaged, retained and monitored is another important element in our model. While TASC has many centralized staff, care coordination and case management functions in its statewide offices, we also co-locate many of our staff with network providers and our referral sources. This allows for immediacy of care coordination and case management relationships and functions as well as the ability to exchange information quickly. TASC case managers may be mobile, conducting home-based services, and may be co-located in hospitals, courts, schools, probation offices and in many other community locations. While we also have a central call center and web site for communication with our clients and other stakeholders, we find the mobile case management and network management is an important element in building stable and long term relationships. Our model assumes we will continue to co-locate care coordination resources with CCO agencies as well as within the CCO administrative structure, collaborating with medical case managers, for example.

Utilization, Disease and Population Health Management - As an organization, we are increasingly developing our capacity and interest in providing *disease management* – leveraging our screening and assessment functions, early intervention, compliance monitoring, and patient education - and *population health management* functions that leverage our identification of multiple chronic conditions and maintenance of population-specific data.

From the standpoint of population health management, TASC has a unique view into the dynamic of clients who fall out of compliance or are pushed out of care while suffering from multiple chronic conditions. Our ability to identify these cases early and respond in order to coordinate their care is a vital asset. We already perform many of these functions to a certain extent as the behavioral health case management arm of the courts and criminal justice system.

We believe that by doing more in the prevention space and distributing the SBIRT programs noted earlier, we would benefit CCOs considerably. Clearly, our ability to avoid deteriorating chronic behavioral health and medical conditions will help the State prevent cases of disability and the associated higher state share of costs. Medicaid expansion will benefit the State General Fund due to a 100 percent Federal “match” that decreases gradually to 90 percent while cases of disability involve a 50 percent match for both the state and the federal governments.

Early Intervention - One of the access issues we are addressing presently is the need for preventive services or those services at the least intensive end of the continuum. We are currently adapting evidence-based interventions such as Screening, Brief Intervention and Referral to Treatment (SBIRT) to the jail setting. Our model presupposes that CCOs will face the same challenges. Thus TASC recommends developing early intervention services as they will add value and save money in the long term. Health promotion strategies involving health literacy education will be needed among this population.

- c. **Q: 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?**

A: TASC is holding exploratory meetings with primary care and other healthcare organizations to explore their interests in becoming Medicare and/or commercial ACOs and in the pros and cons of incorporating TASC services into their offerings. Our approach to providing services to these entities is very similar to the approach TASC is proposing to Medicaid.

- d. **Q: 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?**

A: Yes.

- e. **Q: 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?**

A: TASC currently serves approximately 20,000 unique individuals annually. The criminal justice-involved mental health and substance use disorders populations we serve span all processing points in Illinois’ criminal justice system. We have developed a robust and flexible infrastructure which is continually refined to meet the evolving and contemporary needs of these populations.

Medical and behavioral health care needs are expected to vary across this population. Some enrollees will require only a basic intervention including

enrollment, screening and patient education services. Others will require intensive case management interventions to engage and retain them in services.

Our approach and infrastructure are sufficiently robust to enable scaling-up quite rapidly. We could readily initiate new services to 20,000 new enrollees. Over the ensuing year TASC could absorb an incremental increase of another 25,000 participants, followed by 50,000 over the next year, and another 100,000 the following year. We estimate this would cover all the then-current segment of the Medicaid population that is involved with the criminal justice system.

References

- ¹ Binswanger IA, Krueger PM and Steiner JF. "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared With the General Population." *Journal of Epidemiological Community Health*, 63(11): 912-919, 2009.
- ² Brecht M, Anglin D and Lu T. *Estimating Drug Use Prevalence Among Arrestees Using ADAM Data: An Application of a Logistic Regression Synthetic Estimation Procedure*. Los Angeles: UCLA Integrated Substance Abuse Programs, 2003; Steadman HJ, Osher FC, Robbins PC, et al. "Prevalence of Serious Mental Illness Among Jail Inmates." *Psychiatric Services*, 60(6): 761–765, 2009; Center for Mental Health Services' GAINS Center. *The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails*. Delmar, NY: Center for Mental Health Services' GAINS Center, 2002 (revised 2004).
- ³ National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*. Washington: National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, 2006.
- ⁴ Dennis ML and Scott CK. "Intervening in the Recovery Process." (Presented at the NIDA Meeting on Treatment and Recovery Process, Bethesda, MD, January 15–16, 2004.)
- ⁵ National Institute on Drug Abuse. *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*.
- ⁶ Wang EA, White MC, Jamison R, Goldenson J, Estes M and Tulsy JP. "Discharge Planning and Continuity of Health Care: Findings From the San Francisco County Jail." *American Journal of Public Health*, 98(12):2182-84, 2008.
- ⁷ Mental Health America (2010). Position Statement 56: Mental Health Treatment in Correctional Facilities. Retrieved June 29, 2011 from <http://www.mentalhealthamerica.net/go/position-statements/56>
- ⁸ Illinois Department of Corrections. (2010). Annual Report FY09. Springfield, IL: Accessed online April 2011 at http://www.idoc.state.il.us/subsections/reports/annual_report/FY09%20DOC%20Annual%20Rpt.pdf
- ⁹ Illinois Criminal Justice Information Authority, 2009 Data, Accessed online April 2011, at <http://www.icjia.org/public/sac/raw.cfm>; Jail tab 2008 column
- ¹⁰ Illinois Supreme Court 2009 Annual Report, Accessed on line April 2011 at http://www.state.il.us/court/SupremeCourt/AnnualReport/2009/StatsSumm/2009_Statistical_Summary.pdf
- ¹¹ The National Commission on Correctional Healthcare (March 2002). *The Health Status of Soon-To-Be-Released Inmates, A Report to Congress, Volume 1* Chicago: National Commission on Correctional Health Care.
- ¹² Bonita M. Veysey and Gisela Bichler-Robertson (April 2002). Prevalence Estimates of Psychiatric Disorders in Correctional Settings. In *The Health Status of Soon-to-be-Released Inmates A Report to Congress, Volume 2 April 2002* Retrieved June 29, 2011 from http://www.ncchc.org/stbr/Volume2/Report4_Veysey.pdf
- ¹³ American Psychiatric Association. *Diagnostic criteria from DSM-IV (1994)* Washington, DC: Author.
- ¹⁴ Office of National Drug Control Policy. (2009). *ADAM II: 2008 Annual Report*. Washington: Office of National Drug Control Policy, Executive Office of the President.
- ¹⁵ James, D. J. (2004). *Profile of Jail Inmates, 2002*. Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.
- ¹⁶ Mumola, C. J. and Karberg, J. C. (2006). *Drug Use and Dependence, State and Federal Prisoners, 2004*. Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.
- ¹⁷ Langan, Patrick and Levin, David (2002). *Recidivism in Prisoners Released in 1994*. Washington, DC: Bureau of Justice Statistics.
- ¹⁸ James, D. J. (2004). *Profile of Jail Inmates, 2002*. Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.

TASC Response to Request for Information
Coordinated Care Key Policy Issues

- ¹⁹ Cropsey KL, Wexler HK, Melnick G, Taxman FS, Young DW (2007). Specialized Prisons and Services: Results from a National Survey. *Prison J.* 2007; 87:58-85.
- ²⁰ Binswanger IA, Krueger PM and Steiner JF. "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared With the General Population." *Journal of Epidemiological Community Health*, 63(11): 912–919, 2009.
- ²¹ Pew Center on the States, 1 in 100 Behind Bars in America 2008, Accessed online June 30, 2011 at http://www.pewcenteronthestates.org/uploadedFiles/8015PCTS_Prison08_FINAL_2-1-1_FORWEB.pdf
- ²² Maruschak L.M. and Beck A.J. (1997) *Medical Problems of Inmates*. U. S. Department of Justice, Bureau of Justice Statistics Special Report, NCJ 181644, January 2001.
- ²³ Hammett, T. M., Harmon, M. P., & Rhodes, W. (2002). *The Burden of Infectious Disease among Inmates of and Releasees from Correctional Facilities*. In *The Health Status of Soon-to-be-Released Inmates: A report to Congress: Vol. II*. Chicago: National Commission on Correctional Health Care.
- ²⁴ Springer, SA, Altice FL, Managing HIV/AIDS in Correctional Settings, *Current HIV/AIDS Report*, 2005 Nov;2(4):165-70. Accessed online June 30, 2011 at http://www.ncbi.nlm.nih.gov/pubmed/16343373?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DiscoveryPanel.Pubmed_Discovery_RA&linkpos=3&log%24=relatedarticles&logdbfrom=pubmed
- ²⁵ MacNeil JR, Lobato MN, Moore M, An Unanswered Health Disparity: Tuberculosis Among Correctional Inmates, 1993-2003, *American Journal of Public Health*, 2005 October; 95(10): 1800–1805, doi: [10.2105/AJPH.2004.055442](https://doi.org/10.2105/AJPH.2004.055442). Accessed online June 30, 2011 at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449439>
- ²⁶ Cropsey KL, Wexler HK, Melnick G, Taxman FS, Young DW (2007). Specialized Prisons and Services: Results from a National Survey. *Prison J.* 2007; 87:58-85.
- ²⁷ David Mancuso, PhD and Barbara E.M. Felver, MES, MPA (2010). In *Health Care Reform, Medicaid Expansion and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention*. Retrieved June 26, 2011 from <http://www.dshs.wa.gov/pdf/ms/rda/research/4/84.pdf>

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Chicago, IL 60642
(312) 787-0208
(312) 787-9663 fax

Area 2

401 W. State St., Ste. 700
Rockford, IL 61101
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(815) 964-5784 fax

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2100 18th Ave., Suite 5
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(309) 788-1580 fax

Area 4

456 Fulton, Suite 310
Peoria, IL 61602
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3 Old Capitol Plaza W., Suite 8
Springfield, IL 62701
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(217) 544-0847 fax

Area 6

116 West Main St.
Urbana, IL 61801
(217) 344-4546
(217) 344-8486 fax

Area 7

218A West Main, 2nd floor
Bellefonte, IL 62220
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(618) 277-0417 fax

Area 8

810 Locust, Suite 3
Murphysboro, IL 62966
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(618) 565-1901 fax

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103 Plaza Court
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(618) 656-7938 fax

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Roosevelt Glen Corporate Ctr.
Building 6, Suite 2
799 Roosevelt Road
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(630) 858-7432 fax

Area 11

16 West Van Buren, Suite 102
Joliet, IL 60432
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(815) 727-0725 fax

Statewide Programs & Services

Adult Court & Probation Services
(Clinical Case Management)
Corrections & Community Reentry
(Clinical Case Management)
IDOC Reception and Classification
(Substance Abuse Screening)
Inner Circle and Winners' Circle
(Recovery Support)

Area 1: Cook County

All Statewide Services, plus:
Access to Recovery
Cook County Drug Court
Cook County Mental Health Court
Health Services Case Management
IMPACT (Integrated, Multi-phase Program of
Assessment & Comprehensive Treatment)
Juvenile Court Drug Program
Juvenile Evening Reporting Center
Juvenile Halfway Back
Juvenile Justice Services
Juvenile Parole Readjustment Program
Recovery Coach Program
State's Attorney's Drug Abuse Program
System of Care
TASCLabs
Westside Reentry Adult Program
Women Returning Home (WRH) - ACCESS

Area 2: Northwest Illinois

All Statewide Services, plus:
Driving Under the Influence Program
Juvenile Justice Services
Lee and Winnebago County Drug Courts
TASCLabs

Area 3: Western Illinois

All Statewide Services, plus:
Rock Island County Drug Court

Area 4: North Central Illinois

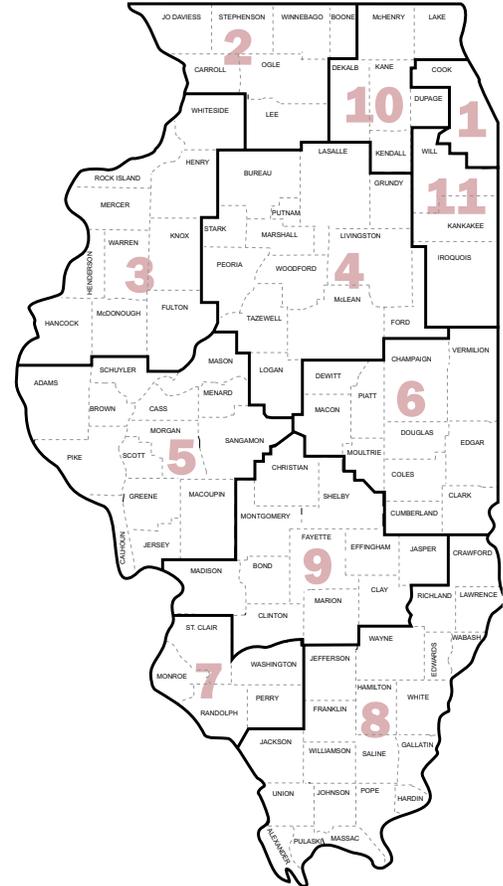
All Statewide Services, plus:
Access to Recovery

Area 5: West Central Illinois

All Statewide Services, plus:
Juvenile Justice Services
Adams, Jersey, Mason, Morgan, and Pike
County Drug Courts

Area 6: East Central Illinois

All Statewide Services, plus:
Champaign, Coles, and Vermilion County
Drug Courts
IDOC Females in Transitions



Area 7: Southwest Illinois

All Statewide Services, plus:
Domestic Violence Diversion Program
Juvenile Justice Services
Recovery Coach Program
State's Attorney Drug Abuse Program
St. Clair County Drug Court
Youth Enrichment Services

Area 8: Southeast Illinois

All Statewide Services, plus:
Juvenile Justice Services

Area 9: South Central Illinois

All Statewide Services, plus:
Detention Home Expansion Project
Juvenile Justice Services
Madison County Drug Court
Recovery Coach Program

Area 10: Northern & Western Collar Counties

All Statewide Services

Area 11: Southern Collar Counties

All Statewide Services, plus:
Kankakee County Drug Court