AIDS FOUNDATION OF CHICAGO 25 YEARS
A FORCE FOR CHANGE SINCE 1985

200 West Jackson Blvd.
Suite 2200
Chicago, IL 60606

Tel. (312) 922-2322
Fax (312) 922-2916

THE COORDINATED CARE PROGRAM -- KEY POLICY ISSUES

Comments submitted by the AIDS Foundation of Chicago to the Illinois Department of Healthcare and Family Services, July 1, 2011

Contact: John Peller, Vice President of Policy, jpeller@aidschicago.org

Thank you for the opportunity to submit comments on care coordination. The AIDS Foundation of Chicago (AFC) supports efforts to improve care for Medicaid recipients—including people with HIV—to improve health outcomes and lives, and to better control health care spending.

An estimated 46,000 people with HIV are living in Illinois, including about 10,000 who have HIV but don't know it. AFC recently partnered with the Department of Health and Family Services (HFS) to compile and analyze data on the Medicaid expenses incurred by HIV-positive Medicaid beneficiaries. Among Medicaid's 11,278 HIV-positive clients, 11% accounted for 50% of the total group's Medicaid expenses in FY08 – with a significant amount of services consumed by homeless people. By 2014, the HIV population enrolled in Medicaid will likely double, and healthcare costs will likely grow exponentially.

Care coordination must be a central element of Medicaid expansion. We strongly encourage HFS to consider two existing networks to facilitate care coordination: supportive housing, and HIV case management.

Demonstrated HIV Care Coordination Successes

Supportive Housing: AFC led the Chicago Housing for Health Partnership (CHHP) research and demonstration project in 2003-2007. CHHP proved that AFC's supportive housing model with intensive support services decreases chronically ill homeless clients' use of costly health services and improves client outcomes. CHHP clients used 2/3 fewer nursing home days, were 2.5 times less likely to use an emergency room, and were hospitalized for a mean of 1.5 days, compared to 2.3 days for the control group. AFC is now completing enrollment in its newest supportive housing project, The Samaritan Program, extending the program's benefits to 195 highly vulnerable, homeless and chronically ill individuals.

Northeastern Illinois HIV/AIDS Case Management Cooperative: For over 20 years, the Northeastern Illinois HIV/AIDS Case Management Cooperative has developed a coordinated, *multi-level system* of case management that links people with HIV to services with varying degrees of intensity that are tailored to meet their individual needs. AFC's medical case management system is widely seen as a

national model. There are currently three levels of case management within the system: intensive, medical, and supportive. See the last page of this document for a detailed description of each tier.

Care coordinators providing intensive and medical case management could serve as expert providers within a variety of coordinated care arrangements:

- Intensive case management targets clients with exceedingly high levels of need, including HIV-positive people who are homeless, have chronic or mental illness, or are pregnant and living with HIV. The program focuses on housing and stabilizing clients, facilitating active links to primary and specialty medical care and other core services, and emphasizing treatment and appointment adherence through frequent client contact.

- Medical case management is targeted to individuals whose cases are less complex. The program focuses on the coordination of medical care and medication adherence support as the basis for promoting clients' quality of life and reducing costs.

We strongly urge HFS to encourage care coordinators to work with the existing, long-established, highly specialized HIV Case Management Cooperative instead of creating new case management arrangements that could duplicate or weaken the existing system while lacking specialization and access to HIV-specific resources.

We are eager to work with HFS and care coordinators to improve the lives of people with HIV. Answers to some of the questions HFS posed are below. For clarity, we deleted questions that we did not answer.

1. How comprehensive must coordinated care be?

a) Do you think that coordinated care should require contracts with specific entities that arrange care for the entire range of services available to a client via Medicaid, across multiple settings and providers? Are there any alternatives you would recommend for consideration?

ANSWER: Some specialized providers are best suited to provide a certain types of services. For example, HIV case managers have unique access to services that are restricted to people with HIV, such as food and nutrition support or housing. We believe strongly that people with HIV should have one case manager who coordinates all services provided to the client, regardless of payment source. Multiple case managers or care coordinators will likely complicate care.

b) 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?

ANSWER: The requirements should be flexible and based on the need of each enrollee. The sickest people with HIV will require intensive services, while healthier people will be able to manage their

own care. Individuals should be able to move through various levels of services as needed, from intensive with a very low client-case manager ratio (15-1) to a less intensive relationship.

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

ANSWER: Faster payment of claims should be explored as one way to incentivize participation.

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

a) 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?

ANSWER: We encourage HFS to adopt different measures for different kinds of clients. For medical care people with HIV, the Health Resources Services Administration (HRSA) released in January 2011 the "Performance Measures Guide for HIV/AIDS Clinical Care", available at http://www.aids-etc.org/aidsetc?page=cg-104_hrsa_indicators. These performance measures could be adopted for people with HIV.

The guide lists specific performance measures for HIV care, such as prescription of antiretroviral therapy (ART) for pregnant women to prevent HIV transmission to the newborn; providing two or more CD4 T-cell count lab tests performed each year or having two or more medical visits in a single year. Most of these measures could be obtained from claims data, but some would have to be extracted from patient records (such as the number of patients with an AIDS diagnosis who were prescribed prophylaxis for pneumonia).

Most publicly-funded HIV providers in Illinois are submitting some or all of this data to HRSA.

b) 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?

ANSWER: HFS should strongly consider a special measure for populations that face multiple challenges accessing medical care, such as people who are homeless or dually diagnosed. While these patients will need more intensive care coordination to engage them in services and manage their health, it is critical that HFS recognize that it will be extremely challenging to manage their care.

c) How will we know when we have achieved care coordination, i.e. how should we measure success?

ANSWER: While we cannot provide a specific answer, we encourage HFS to publicly report on the quality of care that providers achieve. Tools should be available (for example, on the HFS website) to compare providers. Doing so will allow stakeholders and the public to independently assess success.

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

a) 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?

ANSWER: HFS should not require a minimum number of enrollees to allow maximum flexibility to establish creative and specialized care coordination arrangements. For example, New York has created HMOs exclusively for people with HIV. The population is relatively small, but providers can develop highly specialized networks that improve the quality of care, ultimately saving HFS money.

b) Should special arrangements be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

ANSWER: We encourage HFS to provide flexibility to organizations that want to take on challenging clients. A good example is homeless people with HIV and other co-occurring conditions. A strong network of coordinated health care and supportive housing providers could provide excellent care to such a population and demonstrate significant savings by reducing unnecessary care and improving health outcomes.

6. What should be the requirements for client assignment?

a) The Medicaid reform law requires that clients have choices of plans, as do federal regulations. Would it make sense to limit the choices of clients by underlying medical conditions? (For instance, can all clients with specified behavioral health issues be required to choose among a different set of providers than clients not so identified?) Is this practical?

ANSWER: Client choice is a critical issue for people with HIV. It is essential that people with HIV have access to specialists who can provide state-of-the-art care, and they should be able to choose between a number of qualified providers. A client should not be forced to leave a provider that he or she has been seeing for a significant period of time, if the provider is effectively managing care and meeting quality benchmarks.

Specialized networks that are open only to people with HIV could offer significant health benefits to clients. However, they should not be forced to join these care arrangements, but should be free to choose a network that best meets their needs. While it may not be efficient to create more than one HIV network, clients could choose to enroll in the HIV network or another similar network that would meet their needs by providing a broader range of services.

b) 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)?

ANSWER: We strongly believe that providers should be able to limit the clients they accept to special needs populations, including people who are homeless. This would ensure the continued viability of specialized, expert systems that the state, non-profit, and philanthropic sectors have developed over many years. However, clients should not be forced to join these specialized systems.

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

a) Although not strictly a coordinated care issue, how can continuity of care be maintained for low income clients across Medicaid and other subsidized insurance programs--such as will be provided by the Health Benefits Exchange under the ACA? In that respect, how important to continuity is a Basic Health Plan (a provision in the ACA that allows States to create a plan for clients with incomes between Medicaid eligibility and 200% of the Federal Poverty Level)?

ANSWER: While we do not yet have a position on the Basic Health Plan, continuity of care will be critical for people with HIV. Switching providers every time income changes could be extremely detrimental to the health of people with HIV and could severely interrupt access to care and health outcomes. A robust, specialized HIV case management system could smooth the transition between providers and ensure continuity of care.

b) What rights, if any, should the client have to continue a medical home relationship in changing circumstances?

ANSWER: Clients should have the right to continue a medical home relationship through a single case agreement or similar tool. HFS should require care coordination entities to offer single case agreements for patients who have unique medical needs, including people who are HIV-positive. The single case agreement offers strong potential to ensure continuity of care in situations that could otherwise be unstable and disruptive to care.

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

ANSWER: Clients should be able to access complete, current data on plan quality, which should be publicly accessible online and in other formats. See the previous comments on HRSA HIV quality data.

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

a) How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care Networks or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't

sure how your organization would participate, what would be some of the factors impacting your choice?

ANSWER: As previously described, AFC coordinates the Northeastern Illinois HIV/AIDS Case Management Cooperative, which could be easily adapted to provide case management to people with HIV within a variety of care coordination models.

AFC's supportive housing network is ideally situated to help people with chronic illnesses (including HIV) who are homeless or need intensive supportive services to maintain their health and dignity. As we noted earlier, this model has been demonstrated to reduce nursing home, emergency room, and hospital utilization and improve health.

b) 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?

ANSWER: We would consider working within an ACO to coordinate care for people with HIV.

c) 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?

ANSWER: For the past 20 years, the Northeastern Illinois case management system has been coordinating care for people with HIV, including many who are extremely sick or experiencing multiple, chronic conditions. The case management system is prepared to immediately begin coordinating care.

OVERVIEW: Northeastern Illinois HIV/AIDS Case Management Cooperative

The Northeastern Illinois HIV/AIDS Case Management Cooperative features a coordinated, *multi-level system* of case management that links individuals to services with varying degrees of intensity that are tailored to meet their individual needs. There are currently three levels of case management within the system:

Tier 1: *Intensive case management* is a model that targets clients with exceedingly high levels of need, like clients who are homeless, have chronic or mental illness, or are pregnant as well as HIV-positive. Focus on housing and stabilizing clients, facilitating active links to primary medical care and other core services, and emphasizing treatment and appointment adherence through increased frequency of client contact. Client eligibility differs for each intensive case management program. Programs include: *Division of Rehabilitative Services (DRS) Case Management, Corrections Case Management, Supportive Housing Programs (SHP) Case management,* and *Pediatric AIDS Chicago Prevention Initiative (PACPI) Case Management*.

Tier 2: *Medical case management* focuses on facilitating active links to primary medical care and other core services with an added emphasis on treatment and appointment adherence. Clients are

eligible for medical case management if they meet the following criteria: been diagnosed as HIV-positive within the last 18 months; do not have a stable medical provider; identify a stable medical provider but have not had an actualized visit in over six months; or have demonstrated non-adherence to prescribed medications.

Tier 3: *Supportive services case management* serves clients with low need. Tier 3 services consist of various client support services that maintain client access to transportation, Emergency Financial Assistance (EFA), and Emergency Housing Assistance (EHA). Clients are eligible for supportive service case management if they are medically stable, but still need other support services, such as benefits, legal assistance, housing or transportation.

All case management clients are assigned to the appropriate level of case management based on intake assessments and regular re-assessments. Because AFC coordinates this multi-level system for all provider agencies in the Cooperative, clients can seamlessly move from one tier to another as their needs change, without experiencing any disruption in services.

AFC is also developing a fourth tier of case management that will provide services that are particularly suited to support the most self-sufficient clients.