From:	Vince
To:	HFS.Webmaster
Cc:	Gordana; Ginnie
Subject:	IAFP Comments on IDHFS Coordinated Care Program
Date:	Friday, July 01, 2011 1:08:11 PM
Attachments:	IAFP comments on IDHFS coordinated care program.pdf

---

July 1, 2011

Julie Hamos, Director

Illinois Department of Healthcare and Family Services

RE: Comments on Coordinated Care Program: Key Policy Issues, June 2011

Dear Director Hamos:

Attached, please find comments from the Illinois Academy of Family Physicians (IAFP) on the IDHFS Coordinated Care Program: Key Policy Issues, June 2011. IAFP is the professional medical specialty society for Illinois' family physicians. With 3800 members, IAFP represents the largest primary care medical specialty in the state. IAFP's mission is to promote excellence in the health and well-being of the people of Illinois through support and education of family physicians and the families and communities they serve.

For more information, please contact me via phone, 630-427-8002, or email, vkeenan@iafp.com

Sincerely,

Vincent D. Keenan, CAE

Executive vice president

Office 630-427-8002

ILLINOIS ACADEMY OF FAMILY PHYSICIANS

4756 Main St. Lisle, IL 60532 630.435.0257 or 800.826.7944 (In Illinois)

iafp@iafp.com
www.iafp.com

Comments on the Coordinated Care Program, Key Policy Issues, June 2011

The Illinois Academy of Family Physicians (IAFP) wholeheartedly supports the concept of enrolling 50% of the Medicaid population into a coordinated care program. IAFP believes that the Patient-Centered Medical Home (PCMH) is the foundation on which the coordinated care program can be built.

Build on foundation of Illinois Health Connect and Your Healthcare Plus

Illinois has had five years of positive experience using PCMH as the framework for the Medicaid program's primary care case management project (known as Illinois Health Connect) and the Medicaid program's chronic disease management program (Your Healthcare Plus). See Case Statement on both programs, www.iafp.com/PR/CaseStatement.pdf

In 2006 when Illinois Health Connect and Your Healthcare Plus began, the Medicaid program was primarily a payment system based on a fee-for-service model. As 1.5 million Illinoisans were enrolled in Illinois Health Connect in 2007, most patients had their first opportunity to choose or be assigned to a PCMH. The Medicaid program had begun to move from merely a payment system towards becoming a health system. At present, 1.8 million Illinoisans are enrolled in Illinois Health Connect. The clinical results of the program showed improvement as Illinois Health Connect matured.

	2007	2008	2009
Children ages 0-3 at least 1 objective Developmental screen	25.5%	29.3%	36.1%
Women ages 42-69 receiving at least One mammogram in past two years	37.45%	37.36%	38.86%
Adolescents receiving check up Every other year	50.84%	51.51%	54.11%

Your Healthcare Plus engaged 280,000 Illinoisans in chronic disease management, using a more intensive model than had been experienced with chronic disease management programs in other states. An Illinois-based field staff of more than 180 professionals (such as nurse case managers, social workers, behavioral specialists, and nurse disease specialists) not only provided telephone-based intervention but would visit with patients to create care plans.

As the program matured the financial results were quite impressive. The figures below show savings as measured against expected costs given the trend of rising Medicaid expenses for both programs, state fiscal years 2007 through 2010 (four years)

Illinois Health Connect: $431 million
Your Healthcare Plus: $569 million
Total savings: $1 Billion

From the perspective of Illinois' family physicians, the strides made by the Illinois Health Connect and Your Healthcare Plus projects, are wonderful building blocks for taking the next steps of moving from 280,000 persons having some coordinated care (through Your Healthcare Plus) to perhaps 1.5 million persons having coordinated care by 2015 (with the addition of more Illinoisans covered by the Medicaid with the introduction of the Health Insurance Exchange).

The Illinois primary care provider community participated strongly in the Illinois Health Connect and Your Healthcare Plus projects because the Illinois Department of Healthcare and Family Services (IDHFS) invested in monthly meetings at the beginning of the project with the provider community to help shape the projects. IAFP members reported that they had input into the development and IDHFS worked closely with providers. A trust was built up that was not evident before Illinois Health Connect and Your Healthcare Plus were started. The Medicaid program had a poor reputation among primary care providers for many years before the Illinois Health Connect and Your Healthcare Plus programs were started.. The open-forum discussions to help shape Illinois Health Connect and Your Healthcare Plus were key to changing that reputation. Also, 30-day payment cycles for providers who enrolled in Illinois Health Connect, on-time care management payments and annual performance bonuses, helped the projects to develop positive reputations among primary care providers.

<u>Key components for Care Coordination Program</u>

IAFP advises IDHFS to use a similar approaches to development of the Care Coordination Program that were used in the initial phases of Illinois Health Connect and Your Healthcare Plus.

1. How comprehensive must coordinated care be?

The Patient Centered Medical Home (model) espoused by all the primary care medical specialities (see the Patient Centered Primary Care Collaborative, www.pcpcc.net for details) should be the first step for the Coordinated Care Program. The experience with Your Healthcare Plus shows that behavioral health needs to be an integral compenent of PCMH. IAFP recommends that IDHFS build on the framework established by Illinois Health Connect, which has some basic requirements for medical home, and a blended payment methodology (fee-for-service, care management and performance bonus). The next step would be to introduce levels of "medical homeness", such as those provided as PCMH designation by NCQA. Payments could be tiered based on level of "medical homeness" achieved. While IDHFS could develop its own "medical homeness" scale, IAFP would recommend that IDHFS instead support PCMH designations by the following organizations (NCQA, Joint Commission, URAC and AAHC). The requirements for payment for "medical homeness" need to be explicit but the tiering system would be expected to have requirements that increase over time.

IAFP agrees with the Affordable Care Act's intention to at first stay away from coordinated care coverage for specific diseases. IAFP does not believe in the concept of medical homes for specific diseases or organs. There must a "whole-person" approach which "Patient Centered" Medical Home implies. The American College of Physicians has published a position paper on medical home neighbors, which describes the relationship of subspecialty care with primary care in the medical home. This concept needs to be explored further and can be found here, http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf Also, IDHFS should create incentives and means for different sites of care to collaborate (such as emergency rooms and primary care practices).

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

The Medicaid program already has experience in paying for health care outcomes measured against evidenced-based practices with the Illinois Health Connect bonus payments. In July 2011, for the third year in a row, primary care practices will receive bonuses based on achieving or exceeding HEDIS Medicaid measures. There are only a few measures (mostly preventive services). IAFP suggests that IDHFS expand the measures for FY 2013 to a core set of about 25-30 measures and build from there on an annual basis. As mentioned above, IAFP suggests convening the providers to creates measures and ensure they are evidence-based and reliable measuring is feasible. The provider work group would develop the core set of measurs in FY 2012 and add measures annually. In the commercial sector, health plans and medical groups have achieved reasonable success in starting with a core set and incrementally adding measures.

IAFP proposes that IDHFS set as a goal the following blended payment for FY 2017 (50% fee-for-service, 40% care management and 10% performance bonus).

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

IAFP believes that the current incentives for "meaningful use" through the Medicare and Medicaid programs are such that supplements by IDHFS for practices would not move primary care practices faster towards adopting, implementing or upgrading electronic health records. The marketplace is moving too quickly to set realistic dates for when all practices should be electronically enabled. IDHFS is in a great place to monitor how electronic health records are being adopted and the development of the state Health Information Exchange will have a great influence on how quickly practices convert. A point of information, about 60-70% of family physicians report having an electronic medical/health record. If there is a focus for IDHFS, it would be to enable communications between sites of care (such as Emergency Room and primary care physiicans) utilizing electronic capabilities.

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

Shared savings arrangements, as described in the proposed rules for Accountable Care Organizations, are a topic of considerable attention and a considerable hope for containing costs and improving health outcomes.

Here is a link to the comments made by the American Academy of Family Physicians about the proposed ACO rules, http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/statements/aco052011.Par.0001.File.tmp/MedicareACO052011.pdf IAFP advises IDHFS to hold off on its plans for shared savings until the federal model is resolved.

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

IAFP strongly suggests that the Coordinated Care Program needs to be solidly based on the Patient Centered Medical Home. Special projects could focus on particularly vexing issues, such as transitions of care, optimal emergency room use, and behavioral health. However, the special projects need to support the concept PCMH, not serve as a means of "carving out" care from primary care providers, as was done in the past with unsuccesful results.

6. What should be the requirements for client assignment?

The Illinois Health Connect project serves as a wonderful example of how client assignment can work. Voluntary assignment and option to switch assignments is key. Illinois Health Connect has experienced quite low voluntary switches, though clients are able to switch monthly. Once clients experience the Patient Centered Medical Home, they begin to understand the importance of the patient-physician relationship. Illinois Health Connect has used frequency of visits to a primary care provider, or geography when visit frequency did not correlate, as a means of auto-assignment, when voluntary did not work. IAFP advises that this be continued.

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

IDHFS seems to indicate in the description of this question that the managed care model offers better quality assurance than other models. Data from the Illinois Health Connect project seems to indicate that clinical quality outcomes for the 1.8 million clients in Illinois Health Connect is better than clinical quality outcomes for the 200,000 Medicaid clients enrolled in managed care plans. A recent Commonwealth Fund report shows that publicly traded health plans underperform in terms of quality of care and administrative expenses when compared to both non-publicly traded and provider-sponsored plans. http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2011/Jun/Financial-Health-Medicaid-Managed-Care.aspx IAFP advises that continuing to focus on support of the Patient Centered Medical Home model would help to ensure continuity of care.

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

In a similar manner to how IAFP participated strongly in the development and implementation of Illinois Health Connect and Your Healthcare Plus, IAFP will participate as strongly as possible in the development and implementation of the Care Coordination Program. Family physicians are the only medical specialty that is distributed evenly with the population of Illinois. Family physicians are in the cities, suburbs and rural areas. 80-85% of IAFP members report caring for Illinois Medicaid patients. Illinois' family physicians are committed to caring for all Illinoisians.

For more information, please contact:

Vincent D. Keenan
Executive vice president
Illinois Academy of Family Physicians
Phone 630-427-8002
Mobile 708-997-4930
vkeenan@iafp.com