



THE COORDINATED CARE PROGRAM
KEY POLICY ISSUES

IADDA WRITTEN COMMENTS

Submitted by

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Preface

The State of Illinois' vision for Coordinated Care Organizations (CCOs) creates a unique opportunity for all stakeholders to revisit long-held assumptions about health care, insurance and benefits, health financing, managed care, and business relationships. The Illinois Alcoholism and Drug Dependence Association (IADDA) is pleased to respond to the invitation and has prepared these remarks for the Illinois Department of Healthcare and Family Services (the Department). We appreciate the collaborative spirit of the Department's request for written comments and look forward to the ensuing discussion.

IADDA believes very firmly that by providing new models for governance and organizational structure, CCOs offer significant opportunities for improving overall health care while *bending the cost curve* where Medicaid's highest-risk, highest-cost members are concerned. We support this approach given that Illinois Medicaid is preparing to enroll many thousands of low-income, childless adults with multiple chronic conditions - substance use disorders (SUD) among them - as well as an array of complicated social and rehabilitative needs, at a time when budgets are very tight. This high-risk segment of the population is the very population we have been serving for more than forty years. We expect to continue serving them through our members and the important work they do every day. There is no question that the prevention and treatment of substance use disorders is the keystone to effective health care reform. We and our members look forward to responsibly playing our part in that reform.

Essential Benefits -In the spring of 2010, the Affordable Care Act (ACA) extended MHPAEA ("parity") to the Medicaid expansion slated to begin in 2014 as well as the Health Insurance Exchanges. In both cases, the Law will involve establishing an "Essential" minimum mandatory benefit which includes both mental health and substance use disorders and which will be subject to parity. The resulting impact of this requirement is that Medicaid beneficiaries enrolled in benchmark plans in 2014 will have access to enhanced SUD coverage. In fact, since parity does not apply to standard fee-for-service Medicaid, benchmark benefits in some cases could be a more desirable option than standard Medicaid for individuals with SUDs. To simplify the enrollment process and ensure the best coverage for individuals with SUD, IADDA urges the Department to consider providing the same "Essential" benefits package for individuals across all eligibility pathways. Implicit in the concept of an "Essential" mental health and substance use disorder benefit is the ability to access and receive the most appropriate treatment. Recognizing the chronic nature of SUD and many MH conditions, parity and reform intersect to produce improved coverage and fair practices in managed care. No longer can SUD treatment be managed in a fashion that is more stringent than a medical or surgical condition.

We urge the Department to also recognize that people with substance use disorders will not only need a robust benefit representing the full continuum of care in the "mental health and substance use disorders services, including behavioral health treatment" benefit

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category, but will also will need good coverage under a number of the other categories. Comprehensive Medicaid *and* health care reform should fully incorporate the prevention, treatment and rehabilitation of substance use disorders and mental illness as both primary disabling conditions and co-occurring conditions with other chronic diseases. Designing a robust essential benefit that includes prevention and wellness services as well as chronic disease management is critical to producing real value in our health care systems. The wellness benefit should recognize that individuals with untreated substance use disorders often suffer from other co-morbid chronic medical conditions. This is especially true in the case of chronic conditions such as obesity, heart disease, pulmonary disorders, and diabetes. Research has also shown that stressful or traumatic childhood experiences can lead to social, emotional, and cognitive impairments that can increase the likelihood of unhealthy behavior, disease, disability and premature death. The wellness benefit should recognize that coverage for substance use disorder prevention efforts is critical to preventing these adverse childhood experiences and the subsequent costs to the health care system over the lifetime of those individuals.

IADDA supports behavioral health care reforms that provide the following patient supports and protections: 1) access to community-based providers, 2) screening and identification of SUD in primary care and other settings, 3) referrals to appropriate, adequate and effective substance use disorder prevention, treatment and recovery services are consistently provided and 4) reimbursement is sufficient to meet costs of doing business.

Wellness and Prevention -Finally, any wellness benefit must also promote overall health and wellness by addressing the full array of services needed to support sustained, long-term recovery from substance use disorders. Successful recovery management includes life supports such as housing, transportation, education, employment and social connectedness.

Partnership Model -CCO models represent terrific opportunities to create highly organized and coordinated systems of care with a shared sense of value, risk and reward. Failing to include SUD providers from the beginning in either model would have resulted in a system of care that could not successfully address the underlying cause of many of the chronic conditions it was designed to treat. IADDA and its members are delighted that the State of Illinois and the Department of Healthcare and Family Services is designing its approach to CCOs to include IADDA and our members as essential community partners.

Goals and Objectives -IADDA supports a comprehensive and reasonable approach to SUD prevention, treatment and recovery. A comprehensive approach to designing any behavioral health Medicaid managed care plan must take into account a number of goals, including: preserving access to the safety net for vulnerable and special needs populations; achieving desired treatment and prevention outcomes; reinvesting in community-based provider systems; adequate funding; preserving and creating culturally appropriate treatment and prevention capacity; integration with primary health care; and maintaining costs. Thus, the importance of maintaining the community-based substance use disorder prevention and treatment system for the Medicaid population becomes even more critical. It propels access to community-based behavioral health care, under a Medicaid managed

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care system, to the forefront of any health policy discussion. IADDA encourages a meaningful planning process among all stakeholders to address these goals.

Introduction to IADDA

Established in 1967 as the only statewide advocacy organization in Illinois focusing solely on substance use disorder issues, IADDA represents more than 50 prevention, treatment and recovery organizations across the State of Illinois. Our members serve over 200,000 Illinoisans, their families and communities annually through the publicly-funded substance use disorders treatment system.

Our mission is to advocate for substance use disorder stakeholders including health care professionals, the insured and uninsured, patients and their family members, individuals in recovery, and youth. We envision a healthy society where: alcohol and substance abuse rarely occur; addicted people have access to effective treatment; more people are in recovery; everyone participates in prevention and health promotion; and our laws, public policies, and culture enhance everyone's well-being.

We work hard to educate the general public about the disease of addiction, sharing the message that substance use disorders can be prevented, treated, and that people do recover. We accomplish our outreach and public awareness goals through comprehensive media campaigns, community forums, town hall meetings, press, media and governmental relations.

In support of this vision, our team - in coordination with our Board of Directors – devotes special attention to policymakers in Springfield and Washington, D.C., working with legislators and key stakeholders to develop and implement sound public policy that creates and supports healthier families and safer communities. Our experienced advocates work the issues important to our members and we keep members informed and educated via conferences, training, workshops and webinars.

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 Coordinated Care Organizations (CCOs) that arrange care for the Medicaid population, ensuring access to the entire comprehensive set of services that the state envisions, the services on which Medicaid recipients rely today but in a more organized, efficient and affordable way while achieving higher quality of care.

We also believe that to accomplish this monumental challenge will require CCOs to work with specialist providers of many types, a crucial group of which will be Substance Use Disorder (SUD) providers of the kind that are currently members of IADDA.

With passage of the Mental Health Parity Act and the Affordable Care Act, Mental Health (MH) and SUD benefits are becoming mainstream services under health insurance programs in both public and commercial sectors. This was not the case in the recent past, however. Silos within a unique practice specialty, SUD providers are a part of both the health and social service worlds but not fully integrated within either. While many Medicaid 1915 (b) and (c) waivers have targeted behavioral health services for many years, they have done so through a waiver process, carving-out rather than integrating these services into basic health services program.

SUD providers are now rapidly emerging from this world in which they practiced individually and in small or moderate sized organizations without significant reserves for risk-taking and moderate levels of technology. As a consequence of this history, however, the SUD provider community is less developed organizationally than other health care specialties and will be playing catch-up in the near term. Coordinated care should greatly expedite the full integration of this constituency within health care broadly.

To further accelerate this transition, IADDA is reviewing the possibility of building new capacity that will unite and service its members with a variety of administrative capabilities. These capabilities will strengthen performance along many dimensions from operations to development. The various capacities are often expressed in many organizational forms from Administrative Services Organizations to Preferred Provider Networks and others. Having such capacity would enable IADDA and its members to offer Medicaid and the provider organizations which service Medicaid to incorporate SUD treatment and management capacity with greater breadth and depth.

IADDA supported capacity differs from that offered by national managed behavioral health organizations (MBHOs) as a result of IADDA's intimate knowledge of and

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exclusive focus on Illinois recipients and the communities in which they live. Additionally the IADDA provider organizations themselves will be managing the delivery of services, and as such, will intentionally develop delivery practices that are highly efficient rather than pushing down unrealistic and unnecessary administrative hurdles that inhibit access, drive up provider costs and continue to promulgate a culture of stigma that is only now being addressed through parity and health reform.

- 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 Medicaid to prioritize the award of contracts to those CCOs that are able to provide all elements including SUD services. SUD providers are in sufficient supply to treat current demand, but depending on the rate at which enrollment takes place, this supply may be insufficient and may require some incremental phase-in planning. In addition the capacity to meet all administrative requirements that are likely is limited and in need of supplementation. One area in which SUD providers will require additional capacity is in the area of data communications and information systems. The state of practice is highly variable among our members.

- 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: We define 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 SUD providers and services in their community, and include other specialists.

- 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: Medicaid should be as explicit as possible, given that this is a new system of care. Few individuals or organizations have experience operating in the new mode. Thus potential participants will have many questions that must be addressed.

Care coordinators will be essential to ensure that individuals with multiple chronic conditions and/or with high levels of need are served well. Care coordination is an essential service element for the SUD population. While less care coordination will

be required for those relatively more healthy recipients, virtually all recipients will 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 possibly gain efficiencies by providing certain types of umbrella coverage for all CCO entities. Coverage possibilities might include a master pharmaceutical contract or an information systems development and communications connectivity contract for all CCO provider participants. IADDA's potential development of capacity to service many SUD providers across the State is an example of where an umbrella contract could provide efficiencies, cost savings and better overall quality.

As a general rule, however we are concerned that any such umbrella contract should be a later refinement, not one undertaken initially, in order to foster innovation and creativity initially among the initial CCOs. 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. Once the various CCOs are up and operational for several years, Medicaid will have greater experience on which to base decisions about where crosscutting functions through 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: Information systems and data management support, technical assistance and financial resources for startup and initial operations, multi-year contracts through which one may amortize potentially significant investment costs and upside performance opportunities are four incentives that should stimulate the interest of a wide range of providers.

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 HEDIS, CMS, the 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 those measures for this program would prove effective in arriving at

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standards that are amenable to the public, providers, payers, and policy-makers alike. However, it is important not to impose so many quality measures that they become a significant impediment to performance. The following are five behavioral health quality measures that should be considered:

- **Access to a robust network of qualified behavioral health and medical providers and the necessary range of services.** Access to providers across all levels of care from prevention to chronic care is essential. Providers that offer evening and weekend hours are important. Access to an adequate number of providers is also critical. This can be measured by the appropriate ratios of provider types to enrolled population. Qualification of behavioral health care coordinators and sufficient numbers of them are also important quality management.
- **Fidelity to evidence-based practices and practice guidelines** is important and complex where the medical, behavioral health, social and rehabilitative needs are concerned. This is considerable challenge where the high incidence of multiple chronic conditions exists.
- **Patient Satisfaction/Dissatisfaction** is vital to the measure of program success or failure. To the extent that our population is stigmatized and becomes disaffected, compliance with treatment suffers and the risk of costly crisis care and recidivism rises. Provider satisfaction ratings can help identify quality issues as well.
- **Quality of Life measures.** Key quality of life indicators include reduction in and elimination of the use of substances, shelter/housing, community integration, employability and employment, education, and family reunification.
- **Follow-up and monitoring through entire episodes of care, particularly at each transition in care.** HEDIS Behavioral Health and National Quality Forum (NQF) measures are available for this element.

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: Medicaid should consider certain measures that would be required of all CCOs, with the addition of measures that are condition specific and age or level of disability specific. One group of measures cannot fit all participants equitably, though a few broad categories may.

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: Medicaid should consider client risk adjustment from both a financial and actuarial perspective as well as from a functional perspective. In the case of IADDA

populations, client risk adjustment will remain high relative to the general population. There is a great deal of co-morbidity and chronicity among our population that is documented in the Medicaid literature. Establishing reasonable utilization and payment targets that take these factors into consideration is critical.

- 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: IADDA's position on this matter is that organizations like CMS, the NCQA and URAC can come to consensus with the broad medical community on a reasonable number of quality measures for the general needs of the population as a whole. We also believe that selecting measures for chronic conditions and high-risk populations will require attention and collaboration from leading organizations in the field, and that additional time and resources for implementation will be required. One of the more widely accepted sources of measures are discussed in Recovery-oriented system of care (ROSC), SAMHSA's outcomes measures at the following URL. http://www.pfr.samhsa.gov/docs/Guiding_Principles_Whitepaper.pdf

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

A: We recommend a graduated approach to pay-for-performance or performance-based contracting. We suggest that the Department start with an upside bonus in the initial two years, adding risk for a downside penalty in years three and beyond. We would suggest a 2% bonus incentive would apply in the first contract year followed by consecutive increases of 1% each year for the next two years for a total of 4% which is capped thereafter. In the third year the Department would add a downside 2% penalty possibility which would then increase 1% each year for the next two years. Like the bonus opportunity, the risk penalty would be capped at 4% thereafter.

- 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 meetings to include but not be limited to commercial and other public insurers, self-insured employers, managed care organizations, 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. IADDA recommends that the Department also encourage participation by the Governor's Health Care Reform Implementation Council.

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

A: We believe success should be measured by the degree to which we are able to define and measure incremental improvements in the broader goals of Coordinated Care globally, namely wider access, quality enhancement, cost control and coordination among providers. In achieving the goal of quality improvement, success will be determined by how well we achieve the many individual quality measures for the program. In addition, we must have the principal stakeholders making judgments, including the recipients, by provider organizations, by the Department and the Governor as well as the legislature.

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: IADDA is fully committed 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 both SUD disorders is bound by Federal laws 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 SUD patients unique rights 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 SUD 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).

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We recommend a careful review of the law and position papers prepared by organizations like 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 SUD in Illinois.

That said, we recognize the over-arching importance of coordinating care between SUD, and primary care. There are proven policies and processes which assure that all communication conducted in the interest of treatment and care coordination efforts can be in full compliance with Federal privacy and confidentiality laws. We suggest building upon these successful approaches and methods.

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

It's 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 SUD treatment providers do not meet thresholds established by ARRA HITECH Act for Medicaid and/or Medicare incentives. 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, making it difficult for our members to identify and select qualified software vendors. Additionally, 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. All of these issues and concerns underscore the need for additional incentives and investments if early adoption and implementation are to be successful among substance use disorders treatment providers.

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 and the majority of their clients have a limited electronic communications capability and generally do not have the financing required to adopt and implement health IT systems. Additionally, IADDA providers begin with a steep learning curve and will require technical assistance and training. Therefore investment, grants and incentives are absolutely critical in the immediate present and more so in the future to sustain implementation and training. Financial support must from other sources including the State and Illinois' health care foundations. Our providers are in no position to make financial trade-offs as has been suggested.

- 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 SUD providers at the same rate they do and will for primary medical providers leaving IADDA's SUD providers at a distinct disadvantage. While financial support is critical to this effort, we recognize that our providers must also be held accountable if and when funding and Technical Assistance becomes available.

We suggest that SUD 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% of care costs should provide a sufficient basis to inject risk into a contract. Almost all Illinois SUD providers receive who receive state-grant funding are billing and getting reimbursed on a Fee for Service basis. In addition, a large portion of providers have some experience with third-party insurance; however the level of success and sophistication in billing and reimbursement is quite varied. Nonetheless our providers over the last two years have implemented performance-based contracts through the Department of

Alcoholism and Substance Abuse (DASA). These contracts have a limited degree of risk associated with performance.

- 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: Our members would prefer up-side-risk-only agreements that can be implemented in pay-for-performance or shared savings models. Even with these approaches, however, providers have something to be lost by bad performance, and that something is the amount of the bonus. Losing the bonus is a risk, as is making it.

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

A: Our members are willing to participate in down-side risk arrangements, but would greatly appreciate first having the opportunity to collaborate in an upside-only agreement. This would allow us time to develop good operating principles and practices and establish adequate infrastructure capacity. We would prefer that this opportunity be extended as long as possible and perhaps over a five year period. Successful implementation of this approach is contingent upon clearly defined and appropriate measure(s) of output or outcome against which the bonus can unambiguously be paid or not.

- 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: IADDA does not have a recommendation here. However, IADDA members would prefer to participate with coordinated care organizations that operate in a *shared savings* business model rather than a full capitation model. Our membership are concerned that the motivation under a full risk model is to constrain costs and care unnecessarily, adversely impacting quality, while under shared saving, risk and reward are present but not to the same degree.

- 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: IADDA suggests that the shared savings bonus provisions as well as the 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. IADDA also suggests that 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

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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.

If risk is a necessary part of the CCO equation, then IADDA supports the notion that the CCO should be willing to accept it. Whether, how much and how direct providers should also accept that risk is debatable.

IADDA's core concern is the basis on which risk is calculated for the SUD portions of the health benefit risk. Recently, SUD 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 these services that parity is triggering. Thus SUD services are at risk of being under-funded going forward. The extent to which this concern is addressed reflects the extent to which members are inclined to accept risk.

How much risk is another matter. Certainly, direct SUD providers should be accepting much less risk than the entire CCO entity. The percentage of risk is also of concern. That percent should probably be no more than the percent of risk accepted by the CCO as a whole, and probably less.

Finally, the way in which the risk is structured is of concern. Accepting a pay-for-performance contract is one way IADDA direct providers can accept risk. Accepting a capitation is off the table.

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

A: IADDA has addressed these concerns in the preceding responses.

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 (say for the last three years) of individual recipients enrolled with the coordinated care entity, the adverse selection risk is diminished appreciably. We recognized that accomplishing this is no simple matter. We also recognize and appreciate the importance of simultaneously and equitably tying risk-based payments to the program goals of reduced per capita cost, improved quality and experience of care, and ensuring 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: Medicaid should lead the market because it proposes to change healthcare delivery and affecting this kind of change requires a certain amount of risk-taking behavior on the part of the largest health care financing entity in the State. However, the proportion of the separate risks involved and the scope of those risks must be limited to avoid exposing the State to a catastrophic risk.

Contracting with an unproven entity is a significant but not a catastrophic risk. Contracting with such an entity in a demonstration project is less risky than expecting it to perform in longer term, more mature programs. It would be desirable to select organizations that have proven care models and history of operating performance. But the chance of finding many such organizations for this transformation is unlikely. Thus the Department should be prepared to take such a risk.

- 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 with the caveat that IADDA does not believe that individual provider subcontractors to a CCO should be required to have DOI certification. IADDA members are not insurers and the required reserves for insurers, if applied to IADDA member would likely prevent any participation.

- 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. IADDA would expect those serving special, higher risk populations would need to have considerably more enrollees than those serving lower risk populations because of the lower incidence of higher risk clientele.

- 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: Fully 100% of recipients participating in CCOs should have access to specialty care for a comprehensive range of services including SUD services. Individuals with co-occurring SUD and medical disorders need access to specialty care as well as a comprehensive range of services that include community based prevention, residential, and outpatient treatment as well as recovery support coordination.

- 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. This will be necessary to achieve Medicaid's vision for coordinated care. Some of these organizations that have provided services to those with chronic and co-morbid conditions in which MH & SUD is involved may need unique accommodations.

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 where at all 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 SUD providers 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 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. While this may not be possible under Medicaid, we recommend that for those members newly joining a CCO 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 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: In a limited number of cases a provider will have multiple locations and will be able to offer coverage in many communities and on occasion even on a statewide basis. More typically providers in our specialty will be able to offer communitywide coverage only with exceptions for those covering large cities. We would support the idea that a CCO could limit its coverage to a particular neighborhood, especially if no other organization offers service to that community. We also urge the Department to take into account that there can often be significant differences in service coverage between rural, suburban and urban settings.

- 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.

- 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.

- 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 or a larger network or the participation of a greater number of academic medical centers, while the second would favor those with the 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. We would welcome the opportunity to participate in a demonstration that could edify and improve the subsequent participation options for MH & SUD providers.

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

A: We suspect that it will be necessary for those with dual eligibility to participate in ACOs operating under the Medicare rules that also operate under the Medicaid CCO program. These same organizations may well service members in the State's Health Exchanges.

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: IADDA understands the nature of this challenge and believes that while the Department cannot absolutely ensure continuity in a free market, it can take strategic and tactical steps to ensure that SUD providers remain viable and that our programs remain sustainable. We suggest there are several ways to ensure continuity:

- Adopting policy that ensures a minimum maintenance level of funding and targeted enhancement potential for the current SUD treatment system
- Facilitating integrated (or blended and braided) funding, which facilitates the participation of other state agency interests and commitments to the MH & SUD community, thereby spreading the discontinuation risk by brokering or

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advocating for developing a multi-source funding base – an example of this is Medicaid leadership with the Health Insurance Exchange and possibly commercial insurers as well to adopt the Medicaid SUD provider networks – another example is the Department and the State SUD agencies strategizing about how to optimize existing resources under the new CCO paradigm – other state agencies that could or should be involved include the of children and family services agency, the corrections agency and others

- Encouraging Integrated programming and similar or congruent SUD service and participation requirements and monitoring practices across funding sources
- Providing technical assistance and infrastructure capacity-building support. (IADDA 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 at a disadvantage in remaining viable and continuity of care will suffer.)
- Mandating Reimbursement for Case Management – Substance use disorders are chronic conditions that require IADDA 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 our populations do not lose access to and coverage for our services if and when they become insured by the Exchange.

- 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% of the Federal Poverty Level)?**

A: As stated in the answer to question a. above, IADDA has specific suggestions for ensuring continuity of care. IADDA also believes that the Health Exchange's *Basic Health Plan* is of great import in ensuring continuity of care. Additionally we expect that the CMS definition of *Essential Benefits* and the State's implementation of the *2008 Mental Health Parity and Addiction Equity Act* will ensure continuity for our constituents 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 plans should be required to do so.

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

A: Clients should retain rights for continued access to an existing medical home.

- 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: IADDA 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, our SUD providers 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.

As for rights to appeal adverse utilization review and claims processing decisions, IADDA supports the Appeals requirements in the *Mental Health Parity and Addiction Equity Act (MHPAEA)* 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 (ACA)* 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.

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: IADDA is a membership organization for substance use disorder providers. These providers must be key provider participants in any and all CCOs if the Department is to provide comprehensive services and treat the substance problems of this

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population as well as the co-morbid conditions associated with substance use disorders.

In addition to supporting our members' participation, IADDA is preparing to facilitate our member's participation in the following manner:

- to build the provider network management infrastructure and capacity that enables the development of specialized and appropriately qualified networks that consist of our current membership and possibly other potential members, to provide ongoing consultation, training and education to substance use disorders prevention and treatment providers on the implementation of coordinated care
- to work closely with CCOs, the Department and other health care professional networks to promote the inclusion of substance use disorders prevention and treatment providers in a "whole health" solution to this and other chronic conditions, and
- to advance appropriate scope of services, credentialing, medical necessity guidelines and managed care practices for the substance use disorders treatment field.

IADDA and its members propose to contract with CCOs on an "administrative services only" basis with incremental implementation of performance-based incentives.

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: In addition to advocating for a robust SUD component within the required benefit offerings of CCOs and the full participation of IADDA's members in servicing that benefit, IADDA's Board of Directors and members are interested in exploring the development of Provider Network Administrative Services Organization(ASO) Model and administrative functions for IADDA. Undertaking the development and implementation of this model would represent a significant evolutionary step for the organization. However, this step is an arc in the growth of organizations like ours that is consistent with the organization and growth of primary care, multi-specialty groups and other provider networks that require a cooperative approach to new business environments.

Health care reforms have exacerbated existing operational difficulties for substance use disorder (SUD) treatment providers. These difficulties - operational, financial and infrastructural – pose special challenges for providers who tend to be both small in size and who have historically operated at the narrowest margins of profitability, doing much more business on the basis of grant funding than on fee-for-service reimbursement. Many of our providers serve the population that will soon qualify for Medicaid expansion and CCOs, however many only have a limited relationship

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with Medicaid presently. This is particularly true where credentialing, contracting, reimbursement and billing are concerned.

The challenges IADDA substance use disorders prevention and treatment providers currently face include:

- Marketing in multiple new commercial market segments resulting from health care reform including health insurance exchanges, Medicaid managed care plans, and coordinated care organizations
- Pressure to develop new lines of business resulting from the re-purposing of the substance abuse treatment block grant
- Uncertainty with respect to Scopes of Practice and notions of *Essential Benefits* in reformed business environments
- Addressing staffing and other resource requirements for expanded marketing, contracting, and credentialing
- Increased competition from mental health, primary care, and FQHC providers
- Managing complexity and variability with respect to health information technology, electronic data interchange (EDI), health information exchange (HIE), and certified *Meaningful Use* of health Information

This complexity will be compounded as provider systems confront certification issues and evolving standards for EDI like HIPAA 5010 and ICD-10 implementation.

Strength in Numbers

With few exceptions, SUD treatment providers operate on a very individualized and autonomous basis. While this allows them to maintain a great deal of control it exposes them to weaknesses and a wide range of vulnerabilities when the environment transforms quickly much as it has in the past year and much as it will for the next decade.

Notably, hospitals, clinics, primary care physicians and other specialties have a long tradition of organizing themselves to weather storms and compete for market share in cooperative ways. It is time that SUD treatment providers look to the variety of business models implemented by their peers in the medical field and begin to consider how each might be beneficial to their field.

The opportunity exists for IADDA to address the many challenges facing its members through the establishment of a collaborative organization of one type or another that can interface on behalf of its members with CCOs in Illinois. Options for IADDA network services include:

- Management Services Organization (MSO)
- Independent Provider Association (IPA)
- Administrative Service Organization (ASO)

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- Preferred Provider Network (PPN)

The development of IADDA network service capabilities would ensure a unified approach to addressing the myriad challenges confronting participating providers while creating a viable role for IADDA itself, making it a much stronger stakeholder at the health care reform table.

Advantage CCO

The model offers the Department and CCOs many benefits as well:

- A ready-made network of pre-qualified and credentialed providers under a single delegated agreement
- Pre-negotiated fee schedules and rates of reimbursement
- Administrative simplification with respect to standardized agreements, fee schedules, qualifications, and automated billing practices
- Enhanced information technology and health information exchange infrastructure
- A credible source of consultation and training

Core Services

Whatever model is developed by IADDA, core services transcend models and form the foundation for many important IADDA network services:

- Developing an operations infrastructure that can support core business process needs:
 - Information technology (electronic health records systems, data warehousing, health information exchange)
 - Credentialing
 - Billing and revenue management
 - Contracting
- Assembling independent providers in a collegial and mutually-rewarding business relationship that can exert influence on behalf of all parties
 - Marketing
 - Public policy
- Serving ever larger markets with increasing depth and span
 - Access to adequate network coverage
 - Vertical and horizontal integration with other specialties and provider networks
- Facilitating a statewide presence with branding and communications
- Ensuring access to the full continuum of clinical services
- Enabling Quality Assurance initiatives and Pay-for-Performance programs
- Assisting with negotiations and dispute resolution between payers and providers
- Developing cooperative approaches to procurement (hardware, software, office supply, furniture)

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- Offering discounts on professional services (accounting, legal, insurance)

Benefits of the Model

The benefits of an IADDA Network model will accrue to the State of Illinois who has long been the largest funding source for substance use disorders prevention and treatment. Benefits will also accrue to the statewide network of providers who are so critical to the success of integration, coordinated care, and value-based purchasing of services for people suffering from multiple chronic conditions including SUD. To the extent that the model is successful and sustainable, the State's investments in its providers will have been very worthwhile. IADDA expects this venture to produce a viable field of professionals for many years to come. Other benefits include:

- The approach puts the management and administrative burdens of the provider - tasks that have become extremely complex and burdensome for clinicians - into the hands of trained administrators and managers who are dedicated to the broad-based support of all of their members.
- Network service models reduce overhead by centralizing IT, marketing, purchasing, accounts payable, and laboratory services (to name a few) while helping all parties steer clear of anti-trust concerns.
- Some business models rapidly enable revenue cycle management in the commercial market, certified information systems implementation, data analysis, resource planning, and other functions that depend heavily on informatics for success.
- Strategically speaking, the development of network services will enable IADDA and its members to confidently enter the fray of emerging integrated delivery systems and models of managed care at a time when speed-to-market and execution are essential.
- Developing a viable and sustainable business model for IADDA vastly enhances the long-term prospects of its members while reinvesting to attract talented staff and build a more robust and flexible infrastructure for the future.
- A stronger IADDA and SUD field will be able to fend off competition and seek expanded market share of its own.

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: By virtue of the fact that so few of our provider members serve the Medicare population and the nascent nature of ACOs, IADDA has not had discussions with any ACOs. IADDA is not eligible to become an ACO though we are interested in exploring the model described in sections a. and b. above with ACO entities as well as CCOs.

IADDA believes there is tremendous potential for ACOs in the commercial market beyond the scope of Medicare Shared Savings Programs. There is significant

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evidence to support the optimism and interest on the part of health plans and self-insured employers. To the extent that the ACO is modeled after entities such as Kaiser Permanente, Intermountain Health System, Geisinger Health System, and the Cleveland Clinic, there is no reason that they won't enjoy the same commercial success across sectors in the same fashion as those organizations they're emulating.

IADDA expects that our involvement with ACOs and other payers and hybrid models would be very similar to the model and relationship we are describing for CCOs. We are interested in exploring the development of a provider network management and administrative services entity, in much the same way that primary care and other medical providers are organized into Independent Physician Associations (IPAs) and Management Services Organizations (MSOs) and Preferred Provider Networks. Assuming this vision materializes, IADDA would contract with ACOs and other payers to provide a qualified network of professionals and a range of business operations and processes.

- 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, IADDA believes that its core functions as a provider network manager and administrator could be established before mid-2013. IADDA has been working with subject matter experts, consultants and vendors to plan its development and implementation. We would expect a period of interim management while qualified staff are recruited and trained.

- 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: IADDA's provider members already serve the populations slated for membership in CCOs therefore we believe we our model can absorb all of the anticipated CCO enrollment and growth. We anticipate that as we secure this role for our organization and our members, other providers from across the State will find the model attractive and will join our network.

IADDA views its role as one in which the CCO entity itself is served in agreement with IADDA whereas the CCO participants will be served by our member providers. Finally, because our substance use disorders prevention and treatment provider network already spans all of the communities in Illinois, we expect CCO participants will be spared any disruptions in service.