Response to Request for Comments: THE COORDINATED CARE PROGRAM
KEY POLICY ISSUES
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Margaret Kirkegaard, MD, MPH
Medical Director, Illinois Health Connect
Automated Health Systems

1. How comprehensive must coordinated care be?

While this document does not specifically define *Care Coordination*, it is useful to suggest some parameters for this discussion. Antonelli *et al* have suggested that *Care Coordination* includes a range of medical and social support services beyond medical case management. The goal of care coordination is to help link patients and families to services that optimize outcomes articulated in a patient-centered care plan. Care coordination may address the social, developmental, educational and financial needs of patients and families. Case management is commonly used as a synonym for care coordination but tends to focus on a limited set of predetermined diseases or conditions and guided by potential healthcare cost savings. (http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/May/Making-Care-Coordination-a-Critical-Component-of-the-Pediatric-Health-System.aspx)

The Medicaid population is bimodal. The largest patient group is well-children and their families who are the least costly. The second group are the dual eligibles and disabled patients who use a disproportionate amount of resources. Building on the foundation of the medical home model, HFS should facilitate the development of share support networks. The role of the shared support services is two-fold; the first role is to enhance practice transformation to a higher level of medical homeness using coaching and quality improvement tools. Oklahoma Sooner Care and the Vermont Blueprint for Health incorporate some features of medical home enhancement through a support network. The second role is to facilitate care coordination with particular emphasis on connections to community resources. The North Carolina Medicaid model is the best demonstration of this type of shared network. The Primary Care Extension Program, as outlined in the Affordable Care Act, can also create an infrastructure to support some of these activities. (http://www.stfm.org/advocacy/issues/reform.cfm)

Shared support networks can become the building blocks of more defined Accountable Care Organizations as physician and provider networks mature. In their report for the Center for Health Care Strategies, Highsmith and Berenson lay out several elements of shared support systems and strategies for achieving. (http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2011/Mar/Driving-Value-in-Medicaid-Primary-Care.aspx)

The shared support networks can create an appropriate community-based care coordination infrastructure that can address the "social, developmental, educational and financial needs of patients and families" for the majority of Medicaid clients including most children and parents, while more intensive care management services by medical professionals such as nurses, social workers and pharmacists can be allocated for patients who require most intensive management. Potential models for augmenting case management include:

- Paying medical homes to perform this function (over and above care coordination function for medically complex patients). This model would work well for large system such as academic health centers and multi-specialty groups and some FQHCs who already have some case management capacity.
- Contracting through a separate company like the successful Your Healthcare Plus program

- Integration of capacity for case management into the shared support networks
- Requirement that existing Medicaid managed care plans provide this function such as the Integrated Care Plan
- Expanding the current Recipient Restriction Program that already tracks and manages some high-utilizing patients

The shared support networks can be reinforced by the centralized medical home (primary care case management) infrastructure including the centralized call center, client newsletter, and website.

There is a substantial and growing body of evidence that demonstrates that the medical home model reduces costs by decreasing unnecessary hospital and ED visits while improving care, as well as improving provider and patient satisfaction. (http://www.pcpcc.net/pilot-guide) Anecdotally, family physicians report that very few health plans have additional reimbursement for medical home certification but that working towards that goal was significant in improving care and reducing burnout as well as attracting new physicians to areas of physician shortages. Thus, even if there are no apparent upfront financial rewards, there are downstream rewards for practices to move towards a medical home model.

At this time, requiring NCQA Patient-Centered Medical Home Recognition for all primary care practices who care for Medicaid clients is not feasible. Currently, only 88 physicians in Illinois, as compared to the 5700 physicians and providers who participate in Illinois Health Connect (IHC), have achieved any level of NCQA recognition and the majority of those practices are connected to large, well-resourced systems that do not have a high volume of Medicaid clients.

When defining the attributes of the medical home, HFS should use nationally based standards, including NCQA, URAC, AAAHC and The Joint Commission. Care management fees and other incentives should be tiered to drive the adoption of medical home attributes and increase the overall level of medical homeness. Certain attributes of the medical home model may be more important to this patient population and should be selected as the core of the tiered model. Those attributes may include increased accessibility of appointments (evenings and weekends or walk-in appointments), availability of on-site or closely situated urgent care, co-located behavioral health services, linguistic and cultural competency, robust patient education and use of registries for chronic disease and wellness management.

While the majority of patients should have an medical home through a traditional primary care practice (e.g. pediatrics, family medicine, etc), there needs to be an array of medical homes that can address the biopsychosocial needs of all patients. For example, patients with serious mental illness may require their medical home to be located with the psychiatric care provider who can then coordinate with medical providers.
OSF Healthcare in Peoria is a self-insured healthcare delivery system. Dr. Tim Vega has developed what has been dubbed the “ambulatory intensivist model” for providing care to high utilizing employees who often have multiple co-morbidities and concomitant mental illness. By creating a package of services that address behavioral health issues, significantly expanding visit times and focusing on continuity of care, they have achieved more appropriate utilization of services and high patient satisfaction. Dr. David Meltzer at University of Chicago has proposed that medically complex patients with frequent hospitalizations need to be managed in a more resource intensive setting with “comprehensivists” or hospitalists who also maintain an outpatient practice as the leader of a specialized patient-centered medical home team. The Coordinated Care system adopted by HFS should create mechanisms to foster the development of specialized medical homes, identify patients who would benefit from such environments and facilitate linkage of patients to these medical homes, at the same time rewarding providers for caring for more complex patients. While patient choice for a medical home must be respected as the chief driver of medical home selection, using clinical data, patient reports and claims data to stratify some

patients for more intensive medical homes may be appropriate and a natural extension of the medical home foundation created by the Illinois Health Connect program.

The degree and type of care coordination needed for optimal health outcomes will vary based on patient characteristics, community setting, resources of the practice, patient preferences and a host of other factors. Most patients will not require a designated care coordinator because their medical home can perform these functions (with some integration of shared support networks). Patients with greater co-morbidities may require a higher degree of case management and more specialized services focusing on chronic disease management and/or mental health.

As a purchaser of healthcare for nearly 3 million patients, HFS can exercise some market power for umbrella services such as pharmaceuticals, management of dental network and transportation. The current transportation contract should be examined to ensure that patients have access to services without unnecessary barriers. Until the full development of the Health Information Exchange and widespread adoption of EMRs, HFS could facilitate the adoption of technologies by providing low or no-cost subscriptions to web-based EMRs and disease registries such as DocSite. (http://www.docsite.com/registry/)

Most providers are anxious to identify resources for addressing the social determinants of health. The ability to secure better care for patients would be an incentive by itself to participate in shared support networks. For patients requiring more intensive case management, there should be some shared incentives that promote communication and coordination. With any incentives, it is important to adjust the incentives to the maturational development of the network. A progressive implementation of incentives is favored starting with participation incentives and then adopting incentives for processes such as communication between ED providers and PCPs or communication between specialist and PCPs, and finally progressing to shared outcome incentives that reward efficient care and clinical outcomes such as readmission rates or chronic disease outcomes such as asthma management.

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

Whenever possible, HFS should adopt nationally developed measures such as HEDIS measures. National Quality Forum has developed a set of measures (http://www.qualityforum.org/projects/care_coordination.aspx) specifically related to care coordination. The process of adopting measures should include the following:

- Use of national developed, widely promulgated measures
- Transparent and inclusive process for selecting measures with input from a wide-range of stakeholders such as the Illinois Health Connect Advisory Subcommittees or the Illinois Health Connect/Your Healthcare Plus Steering Committee
- Adoption of core set of measures spanning care coordination, adult and pediatric care, preventive and chronic disease care
- Gradual addition of new measures
- Meaningful pay for performance incentives
- Ability to tailor pay for performance incentives at the provider level. While a broad range of measures is appropriate, too many measures may “dilute” the value of achieving any one specific measure and make quality improvement strategies at the provider level too diffuse. In addition to a mandatory core measurement set, providers should have the ability to choose which additional measures they will plan to achieve over a specified period of time in order to maximize their QI efforts
- All measures are supported by interval data reports
- All measures are supported with provider and client education efforts

- For the majority of measures (e.g. immunization rates, well-child rates) risk adjustment is not required. For clinical outcomes measures for some medically complex patients, risk-adjustment may be necessary so that cherry-picking does not result. Providers who care for the most complex patients should be rewarded for their efforts and not penalized for failed outcomes. The process of risk adjustment should be developed through the steering committee.

As much as possible, HFS should coordinate with other payers in Illinois so that providers have consistent pay for performance measures and can align all practice resources towards the same goals. This will be especially important with the onset of the Health Insurance Exchange program where patients may flow in and out of Medicaid and private plans participating on the Exchange. In Minnesota, all payers are required to participate in Medicaid managed care for part of their overall business. A similar policy in Illinois should be adopted if Illinois decides to expand Medicaid managed care options as opposed to allowing plans to participate in only one side of the Medicaid/Exchange continuum.

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

Illinois Health Connect has created an electronic communication system through the IHC Provider Portal. This allows participating primary care providers to access a list of their current patients called a Panel Roster, which also includes clinical information such as whether or not a patient is due for specific services so it also functions as a registry. Providers can also access quality reports such as a semiannual Provider Profile that shows outcomes on 20 standard HEDIS measures. Over 80% of IHC providers have enrolled in HFS' MEDI system so that they can access these online reports. Expansion of this technology could include two-way communication between providers such as specialists and PCPs or agencies and PCPs and posting of additional "gap reports" that give providers a listing of patients who are missing specific clinical services. This service is free and easily accessible so that practices who cannot afford to adopt an EMR have access to some basic qualities tools such as a patient registry.

To minimize confusion and "transformation fatigue", HFS should continue to support the federal incentives as defined through the meaningful use standards. Instead of creating incentives for the adoption of an EMR, HFS could support subscription services to web-based EMRs and patient registries. This would not only enhance care for patients and allow low-resource practices to adopt EMRs, but would also drive some centralization of clinical data that could be easily exchanged with other state agencies such as IDPH or ICARE.

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

Many providers, who provide care to a large volume of Medicaid patients, are under-resourced and unable to tolerate much, if any, risk. Too much risk will drive providers out of the market and decrease access to care. Risk should be introduced gradually to providers through a gradually expanding set of pay for performance criteria as defined above. In addition, the care management fees should be withheld until each patient has engaged in care with the medical home forcing the practices to outreach more aggressively to clients.

Just as full fee-for- service (FFS) payment models can lead to increased and unnecessary services, full capitation can lead to skimping. (Illinois has a poor history with past Medicaid managed care plans in this regard.) Paul Grundy, MD, the CMO for IBM and chairperson of the Patient-Centered Primary Care Collaborative (http://www.pcpcc.net/), has presented an analogy of "multiple switches" for healthcare payments. His premise is that a high functioning system requires multiple switches in order to fine tune the delivery of care. Based on emerging research, he advises using a blended payment system of FFS, care management fees (tiered to medical

home characteristics and/or patients' characteristics) and pay for performance or shared savings. The one "switch" of capitation vs FFS has failed in both settings.

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

See discussion above.

6. What should be the requirements for client assignment?

The current Illinois Health Connect program has a large degree of experience with client choice and assignment processes. HFS should develop a broader range of medical homes that can be specialized to special patient characteristics (see above). The expanded range of medical home attributes can be recorded in the system so that patients can be advised of their choices when they enroll. This would amplify the "best fit" strategy already successfully employed by the current IHC program. Patients requiring more intensive case management services based on claims data, could be identified prior to medical home enrollment and the enrollment could then be guided to more specialized medical homes.

Automated Health Systems (the parent company of Illinois Health Connect) also provides client enrollment broker services to several states. The choice-driver functions of these systems are varied and sophisticated. For example, in Florida patients can enter their current medications into an interactive website that will match their current medications to the formularies offered by participating health plans.

HFS should consider contracting with provider groups as a medical home rather than individual providers so that groups have more latitude for developing specialized care delivery within their own system.

Auto-assignment should consider various patient and provider attributes. Continuity of care as identified through claims data should be the first and foremost consideration. After that, providers with higher levels of medical homeness should be considered over providers with lower levels of medical homeness. This will drive the adoption of medical home attributes, particularly among high-volume providers such as FQHCs who compete for Medicaid clients. Other states have used auto-assignment as a pay for performance reward that does not require any additional financial resources. Assigning patients to the providers with the lowest bid will not have any positive impact on the quality of care.

Requiring clients to lock into one provider for extended periods of time is not feasible unless there are very robust mechanisms for reviewing and allowing exceptions. Many Medicaid patients experience chaotic lives that necessitate immediate changes in medical home selection. Locking-in creates tension when a sick patient presents to a provider and the provider cannot render care because the patient cannot readily change PCPs. The IHC experience demonstrates very little flux in PCP selection over time. For 1.5 million IHC patients who were continuously enrolled during FY 11, 190,000 or 13% made one PCP change, 22,000 or 1.5 % made two PCP changes and only 3349 or 0.23% patients made 3 or more PCP changes. The IHC Client Surveys show that over 95% of patients are satisfied with the program and with their medical home. Anecdotal feedback suggests that the majority of patients value their medical home relationship and that lock-in is unnecessary. Patient switching is usually a consequence of a change in life circumstances or inability to readily access the current medical home, which should be addressed by promoting accessibility standards.

Dual eligibles represent some of the most medically complex and costly patients in the Medicaid system and should be included in the medial home program.

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

Continuity of care is a cardinal feature of the medical home model and leads to better outcomes and lower costs. Traditionally, managed care plans have disrupted continuity of care by contracting only with certain providers based on cost rather than patient choice, existing provider relationships or quality of outcomes. HFS should be commended for addressing continuity of care and making it a high priority in health reform. If HFS plans to expand the options for Medicaid managed care, then health plans that eventually participate in the Health Exchange should also be required to offer Medicaid plans. Participation in the Health Insurance Exchange should also compel health plans to attend quarterly "Health Plan Council" meetings with all other health plans in IL, including primary are case management, to discuss quality improvement initiatives and align provider incentives.

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

Since the majority of primary care physicians in Illinois participate in IHC, the program has become an "arterial" system for provider education and engagement on a wide variety of quality improvement programs and initiatives. Illinois Health Connect acts as an "integrator" for public health and state-wide programs such as:

Illinois Doc Assist
Regional Extension Centers
IDPH Lead screening and prevention program
Vaccines for Children
ICAAP initiatives such as Bright Smiles (oral fluoride)
Enhancing Developmentally Oriented Primary Care
The Autism Program
IDPH-Chronic Disease Self-Management Program
CHIPRA Grant
CDPH breast cancer disparities initiative
Assuring Better Childhood Development (ABCD III) Grant
Project Launch
ICARE
Medical Homes Network
South Side Health Collaborative
National Children's Study, Greater Chicago Study Center Foundation of Illinois
IDPH, Community Transformation Grant
National Kidney Foundation of Illinois

Illinois Health Connect has created a foundational network of medical homes supported by the centralized provider services and client services call centers, website, and provider and client education tools. Care coordination functions of the medical home can be increased by adopting more medical home requirements, introduction of tiered care management fees and pay for performance for care coordination and clinical outcomes. In addition to improving the medical homeness of the overall network, medical homes could benefit by the development of shared support networks.