

Illinois Chapter, American Academy of Pediatrics (ICAAP)
Comments in response to Illinois Department of Healthcare and Family Services (HFS)
Coordinated Care Discussion Paper
July 1, 2011

These comments are in addition to a joint letter submitted by ICAAP along with other hospital, advocacy and provider groups.

Please note that when a response addresses the specific subquestions offered by HFS for comment, the specific subquestions are referenced below by (a), (b), etc.

How comprehensive must coordinated care be?

ICAAP believes that children are served well by the patient-centered medical home model, headed by a physician who then coordinates with outside entities to provide all necessary care for the patient.¹ This should exist on a continuum based on both patient needs and provider capabilities, not fixed or determined by a defined set of tasks. The role of the primary care medical home in care coordination is a dynamic process driven by the health status and developmental progress of the child, the specific needs of the child and family, the primary care physician's expertise, and the ability of the family and/or other professionals to participate in care coordination.²

Overarching organizations that arrange care across multiple settings such as traditional managed care plans are not necessary for the majority of children (a), and have actually shown to have poorer outcomes and higher cost.³ ICAAP believes that more intensive care coordination models may have a role in supporting the care of children and youth with special health care needs (CYSHCN). Though only 13% of all pediatric patients, these children represent 70% of all pediatric health care expenditures.² However, for the vast majority of pediatric patients enrolled in Illinois Medicaid programs, care coordination via a traditional medical home is sufficient.

In addition, care coordination entities that service patients with special needs, who typically require care from a variety of organizations, should have as their principal mission support of the medical home. These entities should be held to the highest National Committee on Quality Assurance (NCQA) standards and be required to publicly report their performance

¹ Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework. Richard C. Antonelli, Jeanne W. McAllister, and Jill Popp, May 2009. available at: www.commonwealth.org. "Nearly all of the expert informants describe the primary care "hub," health care home, or medical home as the logical and effective center for care coordination."

² Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs. American Academy of Pediatrics Committee on Children with Disabilities. *Pediatrics* 2005;116:1238-1244.

³ M. J. McCue and M. H. Bailit, Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide, The Commonwealth Fund, June 2011.

metrics, so both patients and providers can investigate the quality of the services they provide (d). ICAAP believes, however, that patient participation in these arrangements should be optional so as to minimize inadvertent disruption in care; many of these children are already well served by their primary care providers.

Driven by commercial carriers' interest, as well as HFS initiatives, the patient-centered medical home model is being implemented across the state. ICAAP remains concerned that efforts to encourage the medical home not be punitive. They should support not only documented improvements in quality and systems but efforts to make such improvements, for instance via commitments to pursue formal recognition and participation in HFS approved quality improvement. The process of improvement is challenging, but Illinois needs to support this process in order to maintain the large and accessible network of primary care medical homes it has established via Illinois Health Connect. Relative to large medical groups, small practices are likely to be "behind the curve" and slower in adopting medical home components. In addition, many large clinic systems are composed of small care delivery sites with only 1 or 2 providers, and change in those settings can also be challenging despite the fact that they are part of a larger system. These practices and clinics provide a large portion of the care for children with HFS insurance and need to be encouraged and supported to make improvements, or the state risks losing their participation, which would both reduce access and enhance the disparity in types of provider sites available to those with public versus private insurance.

Through our own initiatives, ICAAP has learned that practices operationalize the medical home in many different ways, and it is counterproductive to insist on any one element or on achievement to a level that only certain practices will ever meet. Put another way, no one facet of the medical home is so sacrosanct that its absence should be viewed with concern.¹ ICAAP agrees with the approach the state has taken so far: measuring outcomes related to a successful medical home (i.e., vaccination rates, ER utilization, etc) and rewarding practices that perform well according to these metrics (c). ICAAP also commends the state for its efforts to date. The current Illinois "medical home program" provides a structure for implementing changes and already verifies some medical home criteria/functionality via the data/application providers submit to Illinois Health Connect, but not all. Illinois Medicaid also lacks an objective verification or assessment/audit process of medical home features. We believe development of a coordinated care program and further operationalizing of the medical home model (c) can go hand-in-hand and be accomplished without creating a two-tiered system where providers who are recognized provide high levels of care and receive related incentives and others never attempt to improve.

National recognition and certification programs such as the NCQA Physician Practice Connections® - Patient-Centered Medical Home™ and others offered (for instance by the Accreditation Association for Ambulatory Health Care (AAHC) and The Joint Commission offer established frameworks for demonstrating medical home functionality along with strong processes for verification. These programs have growing acceptance by medical providers, and tools, training and technical assistance are being developed nationally and locally to align with these programs. HFS should not *require* recognition by NCQA (c) or other bodies. Practices and clinics are only gradually using these programs and achieving recognition is a time consuming process, so implementing a requirement would likely reduce provider participation in Medicaid, particularly in private practices with modest Medicaid enrollment. But HFS should incorporate such recognition programs as options into its incentive program. This will not only align with anticipated efforts of private insurers and with development of resources noted above,

but will also reduce the burden of assessment and verification of “medical homes” on HFS staff or contractors.

Incentives provided to care coordinated networks that increase practice efficiency would be well-received by the provider community; for example, technical assistance to practices for developing electronic medical records (EMRs) would encourage providers to improve their care coordination efforts. For practices that do not yet have EMRs, there are opportunities for care coordination entities to encourage practices to reap their benefits. For example, HFS could instruct IHC to utilize their database to assist in patient reminder calling, vaccine alerts, and other key functions of the EMR (f).

Even with the advent of multiple care coordination entities, ICAAP expects a large role will continue to be played by IHC and HFS. We agree that HFS’s group pharmaceutical purchasing power is a major benefit, both financially and clinically, and we would discourage having this market advantage diluted in multiple regional entities. We would also encourage HFS participation in negotiating for large service contracts such as physical therapy, mental health coverage and laboratory evaluation (e).

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

ICAAP believes that the HEDIS measurements currently utilized by the Department are both rigorous enough to promote child health while having realistic expectations of what medical home practices are capable of providing to their patients (a, b). These measurements, along with others like ER and hospital utilization rates, would give clinicians and HFS administration a meaningful picture of how well their patients are being cared for (g).

ICAAP agrees that the Department should consider some form of client risk adjustment. Medically complex patients require a great deal of care coordination, and recognizing practices that provide care to these children would be a “win-win,” rewarding the practices that already take on these children and encouraging others to do the same. ICAAP has prepared a formal proposal for tiering the care coordination fee based on various factors and would appreciate an opportunity to discuss this with the Department at a future date (c).

Coordination with other payors is critical (f), and we encourage the Department to move in that direction. Adopting a coordinated set of quality measures and related incentives among payors would give providers a clear set of measures toward which to work and encourage coordinated improvement efforts toward goals both providers and payors support, such as improved care coordination, use of technology, etc. Initiating the discussion should be easier in a state like Illinois, where the public insurance system is handled by a limited number of entities (HFS’s PCCM program and three modest managed care plans) and the private system is dominated by Blue Cross Blue Shield of Illinois and a few other entities.

To what extent should electronic information capabilities be required?

ICAAP has concerns that, though EMRs are rapidly being implemented by the provider community, we are still years away from its universal adoption. Practices that are less likely to have EMR capability tend to be smaller practices that lack the necessary resources. Steps on the part of any payor, even one as important as HFS, to incentivize adoption of EMRs must be developed so as not to seem punitive or exclusionary, as they could result in practices reducing participation in that insurance product. Furthermore, there are major, ongoing initiatives in

Illinois to encourage adoption of EMRs and establish health information exchanges. These are already targeted heavily toward Medicaid providers and large health systems, and they include the federally-funded Regional Extension Centers (RECs) and the Governor's Office of Health Information Technology which is planning for regional Health Information Exchanges (HIEs). ICAAP believes these efforts, which are designed to engage all stakeholders and offer providers support, need to continue their work, which has already proven challenging and slow. ICAAP believes federal incentives for EMR are sufficient to promote its use; HFS resources would be better utilized in other ways (b, c, d).

Until EMR is ubiquitous, there are several opportunities for HFS, through IHC, to enhance patient care through electronic information. For example, HFS claims data could be utilized to remind patients when a well care visit is overdue, a vital EMR function that has been shown to dramatically improve patient compliance to primary care guidelines. ICARE data could also be utilized to alert practices to patients who are lacking proper immunization, as well as provide instantaneous information about immunization status to a new practice the patient has recently joined. Finally, a unique opportunity exists to facilitate communication between the PCP and ER by increasing utilization of the "Who's my PCP" IHC function (a). ICAAP believes use of this technology, which is already in place and can grow in functionality without significant resources, should be encouraged and incentivized.

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

In the commercial world, an insurance product is generally considered an "at-risk" product if 10-15% of physician reimbursement is withheld pending the attainment of objective, clinically relevant goals. ICAAP believes this ultimately would be a reasonable definition to apply to the care coordination entities with whom the Department contracts, but during the transition from the current system to one based on risk, we support either establishing "up-side" risk only (b) or putting a more modest amount of physician reimbursement, such as 5-10%, at risk.

Illinois already has the foundation of a blended payment model (the standard fee-for-services payment, a care management fee, and pay for performance) that allows for flexibility. Other than pay for performance, these are applied to providers consistently without regard to the complexity of the patients, the level or quality of care provided routinely, or the improvements in practice systems implemented by the provider. An "up-side" risk arrangement, such as pay-for-performance, is already in place using some clinical measures and could successfully be expanded to encourage providers to improve care delivery and coordination; the success of the current programs and provider acceptance of them should indicate that providers will be responsive. This is the best option for the program in terms of serving the non-disabled pediatric population, since they are generally healthy and require access to additional services rather than limitations on types and levels of service.

ICAAP can also support efforts to put some payment at risk and as noted suggests a reasonable at-risk measure initially to be 5-10% percent. Within IHC, this could be operationalized in several ways, but ICAAP proposes making IHC's care coordination fee at-risk (instead of the current system where it is paid irrespective of clinical outcome). This would put *at minimum* five percent of HFS primary care pediatric payment at-risk, fulfilling the criteria

(a,b,g).⁴ Other states have adopted this approach as well in the hopes of urging practices to better coordinate care.⁵

The goal of at-risk contracts is best achieved when that risk is shared by both the care coordination entity and providers. However, provider risk is imputed in commercial insurance contracts even if it is not specified overtly. Currently, managed care organizations are allowed a medical-loss ratio of 15%; providers understandably view this as reimbursement they have no opportunity to capture irrespective of the quality of care they give their patients.⁶ They view this not as funds “at risk,” but rather as funds that have been diverted to increase shareholder value and pay the salaries of insurance companies. ICAAP is concerned that, within the commercial insurance paradigm, putting additional funds “at risk” based on physician performance will force physicians to reconsider their exposure to HFS patients as reimbursement necessarily declines (d,e,f).

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

ICAAP believes that the Department should—at least initially—contract only with known managed care entities, ones that have been certified by the Department of Insurance with a proven track record in this state. They should be held to the highest HEDIS standards and report publicly the relevant metrics. They should be able to demonstrate adequate access to specialty care, as these are the children most at-risk of adverse health outcomes.

As the introductory comments to the HFS query document note, in some geographic regions significantly more than 50% of children will be mandated to join alternative care coordination organizations. ICAAP remains concerned about the potential disruption to the care of these children if their providers do not accept the managed care product they have been forced to join.

What should be the requirements for client assignment?

ICAAP strongly believes that the default choice of client assignment should be the patient’s current medical provider.⁷ Pediatric primary care providers typically handle a wide variety of chronic conditions such as asthma, autism and ADD; limiting client choice to providers who have officially declared a particular clinical interest would arbitrarily limit patient choice and exacerbate disruptions in care (a). Any arrangement that would force patients to choose a new provider based solely on a medically arbitrary requirement to enroll a given number of people in alternative care coordination entities would be both counterproductive to their health and ultimately more expensive to the state in terms of nonurgent ER visits and preventable hospitalizations. For this reason, we and other organizations devoted to children’s

⁴ The 2011 HFS annual report lists physician reimbursement as a lump sum only; this percentage could be quite higher if the denominator is adjusted to reflect only pediatric primary care reimbursement.

⁵ See for example Minnesota’s program, available at:

http://www.health.state.mn.us/healthreform/homes/payment/PaymentMethodology_March2010.pdf

⁶ Comment letter from Children’s Memorial Hospital on the proposed HFS MCO rule, February 23, 2011. “The solution that MCOs would put in place would be to remove approximately 15% of an already low payment (as allowed by HFS contracts) to cover their own profits and salaries and then attempt to rework payments from one underfunded provider to pay for another.”

⁷ AAP Medicaid Policy Statement, Committee on Child Health Financing. PEDIATRICS Vol. 116 No. 1 July 2005, pp. 274-280.

care have consistently advocated for inclusion of the PCCM in the legislation's 50% requirement (see appendix A).

Given this concern, we recommend that the only patients who are required to enroll in new care coordination entities are those whose providers also accept the new insurance product. In this way, the transition would be seamless to the patient and not disruptive of care. It would also aid the Department in discerning which new care coordination entities are proper investments—if a given care coordination entity was not able to establish a strong provider network, this guideline would prevent the Department from inadvertently moving clients into a sub-performing product. These criteria should be stratified geographically—a robust network in the Chicagoland area does not imply a given product will be able to achieve similar success in other areas of the state (b).

For clients who do not self-assign, this paradigm would also allow the Department to select for the most robust care coordination entities. If in a given geographic area one product has recruited twice the providers of another, it seems reasonable to auto-assign to the product with the larger network, both because it likely will deliver higher quality care and be better able to handle the influx of new auto-assigned patients (d).

ICAAP is not supportive of a bidding process for auto-assignees (e). This would likely drive more clients toward care coordination entities that are incentivized to provide more restrictive care. At the very least, we would suggest medically complex populations be excluded from this process. We also note that this method of auto-assignment is not utilized by other state Medicaid programs.

How should consumer rights and continuity of care be protected?

Though managed care may have “matured significantly” in a general sense, its track record with regards to the Illinois Medicaid program remains problematic. The managed care organizations in this state consistently have underperformed on HEDIS measurements when compared to both the 50th percentile and the PCCM. In geographic areas with managed care options, only 15% of patients choose this form of Medicaid insurance.⁸ Nationally, Medicaid managed care has not delivered on its promise of improved care coordination or access; at least one state is actually dismantling its Medicaid managed care contracts as Illinois seeks to increase their presence.⁹

ICAAP strongly believes that it is counterproductive to force patients to change providers for non-medical reasons. If the patient believes their current provider is adequately meeting their health care needs, this should be sufficient to ensure the patient remains in their current medical home (a). If patients are to be moved, however, there should be a robust, patient-focused appeals process with retroactive payments to non-assigned providers who see the patient prior to the transfer's approval (d). Plans should be held to the highest NCQA standards, including public reporting of all relevant HEDIS metrics so patients can decide which care coordination entities best suit their health care needs (e). ICAAP believes that continuity of care would also be

⁸ Margaret Kirkegaard, MD, MPH, Medical Director, Illinois Health Connect Illinois Primary Care Case Management Program. Testimony for the Illinois House and Senate Special Committees on Medicaid Reform. December 11, 2010. See also: <http://www.hfs.illinois.gov/managedcare/hedis.html>

⁹ “Malloy administration moving HUSKY out of managed care.” CT Mirror, February 8, 2011. Available at: <http://www.ctmirror.org/story/11427/malloy-administration-moving-husky-out-managed-care>.

promoted if care coordination entities offered plans in both Medicaid and the Health Benefits Exchange (c).

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

ICAAP has no current plans to introduce a coordinated care product into the marketplace.

The above information was submitted to be respectful of HFS' deadline of July 1, 2011 and therefore does not represent ICAAP's comprehensive opinion and does not intend to respond to every question posed by HFS in its *Coordinated Care Discussion Paper*.

About ICAAP

The Illinois Chapter of the American Academy of Pediatrics (ICAAP) is the statewide membership organization for pediatricians, with 2,300 members throughout Illinois serving children at diverse sites including private practices, community clinics, academic medical centers, and more. We have extensive experience in systems change both in clinical practice and public systems. Within the health care setting, we help primary care providers adapt systems to improve or expand clinical services and coordinate care with external partners. In community and state systems, our work takes information from health care providers on their needs and the barriers they encounter to providing high quality, comprehensive care and translates that into initiatives that help change public and community systems to be more responsive to health care providers and the families they serve. We engage our pediatrician members and their staff in making changes happen in their communities and at the state level.

For more information on ICAAP, visit www.illinoisap.org or contact Scott G. Allen, MS, Executive Director, at 312/733-1026, ext 202 or sallen@illinoisap.com, or contact ICAAP's representative to the Illinois Medicaid Advisory Committee, Dr. Ed Pont at 630/832-3100 or edpont@pol.net.