WellCare

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Region President

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Ms. Julie Hamos
Director
Illinois Department of Healthcare and Family Services
401 South Clinton
Chicago, IL 60607

Dear Director Hamos:

Harmony Health Plan of Illinois, Inc. is pleased to submit the following responses to the Coordinated Care Program Key Policy Issues paper.

1. ***How comprehensive must coordinated care be?***

Questions for Comment:

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

We recommend that coordinated care should require contracts with entities for the entire range of services. The ability for a single accountable entity to be responsible for all services on an integrated basis and coordination through one entity can serve as the most cost-effective model while promoting quality and outcomes.

An alternative that could be considered is for dually eligible clients. The Medicaid program, there are also persons eligible for Medicare benefits. These dually-eligible clients receive Medicaid cost-share support or Medicaid program benefits. Including coordination for both Medicaid and Medicare dual-eligibles through one entity is also an alternative we would recommend for consideration.

b) ***Must all of these elements be required in any entity accepting the contract, or just some of the elements? Might these change over time, i.e. start with a base set of requirements and gradually increase over time?***

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All of the elements should be required in any one entity accepting the contract, and all entities should be held responsible to the same requirements.

Yes, however, Gradual increases are possible but taking responsibility for all services at the outset of a contract, and having the ability and the contractual obligation for all services is the ideal model.

c) ***Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operationalized?***

Strong provider partnerships and collaboration are essential to effectively serving the Medicaid population. Such local partnerships should drive the clinical model which is built around a member centric approach and a medical home concept. The care management program should take the lead role in assuring integration of care and services between medical homes and other levels of care. This will include integration of acute care and long term care services. A primary care physician will be at the center of the medical home model, as well as the clinician responsible for coordinating acute care services. Each enrollee will be assigned a primary care physician. At the core of this care model will be the coordination of the PCP and the care management program to effectively ensure that the member receives the necessary and appropriate care. Effective integration of care between medical homes and other levels of care is dependent on the following:

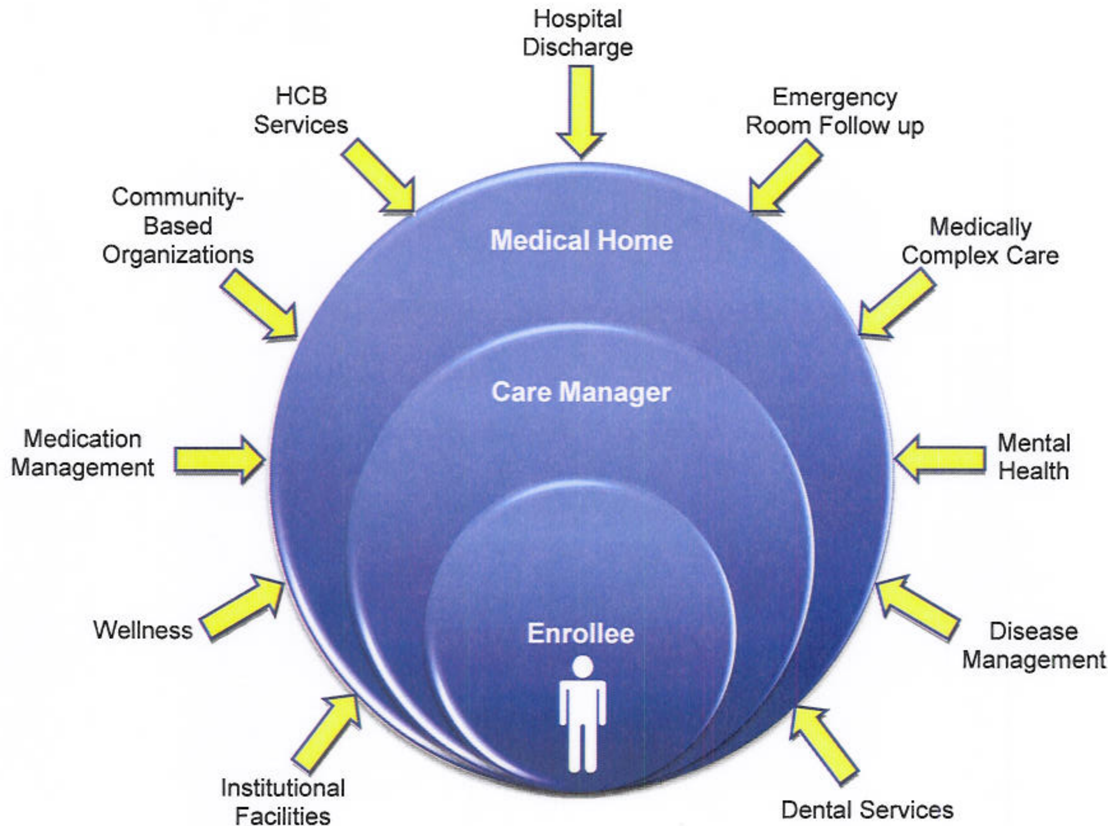
- The medical home understanding the needs of the enrollee;
- The medical home being responsive to the needs of the enrollee;
- The medical home having adequate, timely access to enrollee information;
- Enrollees having timely access to care;
- Providers having timely access to enrollee health information;
- Timely communication and sharing of enrollee health information;
- Ongoing monitoring and evaluation of enrollee care across the spectrum of care; and
- Use of electronic data systems.

Providing every enrollee a medical home will result in enhanced access to care, increased preventive care and early intervention activities, reduced inappropriate use of the ER, and improved coordination of health care services. As a result, it is essential that an enrollee's care manager and medical home function as a team and work in partnership to ensure integration of care across all levels of care, including but not limited to:

- Community-based organizations;
- Housing assistance;
- Disease management;
- Hospital admission and discharge;
- Emergency room follow-up;
- Specialty care;

- Medication management;
- Nutrition;
- Mental health;
- Substance and alcohol abuse;
- Institutional care;
- Transition from institution to community living arrangements;
- Community care and in home support services;
- Wellness; and
- Dental services.

Exhibit



Would the existence of a medical home require NCQA certification? The existence of a medical home does not initially need to be NCQA certified. However, it is important that the entity has the capability through infrastructure, resources and capital to be able to execute on all medical home concept and contract requirements. It is also recommended that the entity have plans to seek NCQA accreditation and to achieve accreditation as part of its quality program.

Would all primary care physicians be required to be in practices that meet these requirements? The burden should be on the contracting entity to provide the systems and support for physician offices to meet and execute on the medical home concept. If individual practices would also be the care coordinating entities, then yes, they should meet these requirements. Moreover, the entity should provide the care coordination tools, data and processes that are essential to effectively operationalize a medical home. These are recommended core contractual expectations the entity should have of physician partners that promote quality and access. It is this capability that will determine if a provider practice can serve as a medical home.

What requirements are essential of every practice? Presumably it would be possible to increase requirements over time. What progression would make most sense?

The following are capabilities and requirements essential for every practice:

a. Care Management – collection and integration of data from the various touch points in the care continuum, including electronic sources for clinical and administrative purposes.
b. Care Coordination – facilitate information exchange between primary care, specialty, and hospitals to effectively manage patient care along the patient care continuum
c. Performance Reporting - ability to measure and report clinical quality of care, patient experience and cost, including identification of areas of improvement and recommended actions to improve effectiveness.

Other than the accreditation, we believe these requirements and capabilities should be part of the core competency of any organization participating in the program on Day One.

d) ***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?***

The requirements about how an entity achieves coordinated care should be very explicit. Specific requirements should center on how the organization can facilitate timely information exchange and member access between primary care, specialty care, and hospitals. Requirements around systems capability, clinical reporting, clinical protocols, and access standards should be outlined.

We recommend a care coordinator be assigned to each enrollee. The ratio of members to care coordinator would vary based on the population to be served. However, each enrollee should have an assigned coordinator.

e) ***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?***

It is not recommended that HFS carve out any umbrella coverage for entities; rather, all services and coverage categories should be required to be provided by the care coordination entity. Having all services be the responsibility of one entity allows for better access to critical data, better coordination of care as there does not need to be a handoff from one entity to another, and greater cost effectiveness through management of member care under one comprehensive care management program.

What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks? Harmony, as well as affiliated plans in other states, has had extensive experience recruiting physicians in key service areas, whether rural or underserved. Various incentives that have been used include the following:

a. Shared Savings : if through effective case management, efficient care and proper care coordination results in savings overall costs, those savings be shared with providers without downside risk

b. Quality Pay for Performance (P4P) Incentives: typical performance programs focus on improving quality scores. Aligning incentives around health care quality and access with our PCP partners can be a powerful incentive. Performance programs reward PCPs for achieving target rates for certain HEDIS measures. An incentive model can focus on mainstream HEDIS measures of health care quality and access for the Medicaid population such as Adult & Adolescent Access, Cervical Cancer Screening, Eye Exams for Diabetics, Diabetes HbA1C Testing, LDL-C Screening for Diabetics, Lead Screening for Children, Childhood Immunizations, and Well Child Visits.

c. Bundled Payments: is a single payment made to a providers for the entire episode of care provided to the patient. Episode of care payment programs may include a quality incentive or gain sharing component.

d. Administrative Fees: much like the PPCM fee, offering a PMPM payment to help with fixed cost and cash flow requirements

e. Reimbursement for Telehealth Services / Group Visits: paying for telephonic visits or other remote diagnostic and clinical support provided by providers. Additionally, payment for group visits is another incentive that Harmony WellCare has used to incentivize participation. Harmony WellCare is also evaluating telemedicine vendors that could connect beneficiaries and their physicians through remote monitoring devices that allows physicians and beneficiaries to communicate medical information to each other for purposes of care management.

We also recognize that certain provider types can be difficult to engage in participating in a program. Specifically, hospitals and some specialists are more difficult to contract. In our experience, incentives implemented by the State can prove effective in enlisting providers. For example, in the state of Georgia,

when the mandatory Medicaid program was implemented, hospitals were notified through legislative action and program design that they did not have to participate with managed care companies in the program. However, as a non-participating entity, the non-par payment would be reduced to 90% of the prevailing Medicaid fee schedule as opposed to the 100% they would receive as a non-par entity through the then existing rules. Similar concepts are being considered by AHCA (Agency for Health Care Administration) in Florida as they prepare for a mandatory procurement for Medicaid services.

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

Questions for Comment:

a) What are the most important quality measures that should be considered?
The most important quality measures are the ones that measure the preventive screenings and specific outcomes of our members based on accepted standards of care. While preventive screenings and specific outcomes related to physician visits or pharmacy claims are easy to obtain, outcomes related to lab results or clinical results are difficult to obtain administratively due to lack of utilization of CPT2 codes in claims submissions and lack of information exchanges that capture clinical data. Since outcomes related to lab codes and clinical outcomes typically require medical record review which is time-consuming and resource-intensive, there are only a few of these quality measures that we propose.

The HEDIS measurements are nationally accepted, already utilized by all insurers, and standardized to compare providers by category of member served. These should be the basis of most if not all the quality parameters established.

We propose the following twenty-five key quality measures:

Preventive Services (15 measures):

- Well-child visits for children 0-15 months, 3-6 years, and adolescents (3 measures)
  - These are the key preventive services for children. These visits provide early and periodic screening, diagnosis and treatment (EPSDT) and are the keys to mitigating any growth and development problems and increasing the overall health of children.
- Childhood immunization status (CIS), combination three, by age two (1 measure).
  - This is a key measure for early childhood immunization completeness prior to the school entry requirement.
- Timeliness and frequency of prenatal visits, and timeliness of post-partum visits (3 measures).
  - Many of our members are pregnant moms and these measures evaluate the appropriateness of the number of services received during the pregnancy.
- Chlamydia screening for sexually active women between 16-20 (1 measure)

- Adult access to preventive/ambulatory health services (1 measures)
- Cervical Cancer Screening- for women 24-64 (1 measure)
- Asthma- Use of appropriate medications for people with asthma. (1 measure)
    - Asthma is a key chronic disease, with high rates of morbidity and mortality in our population and in Chicago in particular.
- Comprehensive Diabetes Care: HemoglobinA1c, LDL and nephropathy screening (3 measures)
    - Diabetes is also a chronic disease with high rates of frequency in our population.
- Follow-up within 30 days after a hospitalization for mental illness (1 measure)

Outcomes (10 measures):

- ER visits/1000 (1 measure)
- Percent of live births at 2500 grams or more --*needs standard as not a HEDIS measure* (1 measure)
- Comprehensive Diabetic Care; HgbA1C<8-*needs CPT2 codes* (1 measure)
- Appropriate testing for children with pharyngitis (1 measure)
- Appropriate treatment of Upper Respiratory Infection (URI) (1 measure)
- Annual monitoring for patients on persistent medications (1 measure)
- Anti-depressant medication management-acute and continuation (2 measures).
- Pharmacotherapy management of COPD-bronchodilator; systemic corticosteroid. (2 measures)

b) 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?

There will be some measures that will apply only to children and other that apply only to adults. The well-child measures and CIS apply only to children and cervical cancer screening applies only to adults of a certain age. However, others like the chronic and acute conditions like asthma, diabetes, ER visits and upper respiratory infections should apply to persons of all ages. Additionally the pregnancy measures apply to women of any age who are pregnant.

These measures in general should apply to all populations although some measures will not apply to one population or the other.

c) 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?

These measures are standard measures used across the country for multiple populations, including the populations discussed in the Coordinated Care Program.

The only measure where there may be an adjustment needed is for the ER visits/1000. The disabled population may have more chronic conditions and there may be a skewing of the ER visits/1000 due to the specific population demographics.

If there are not enough members in the population, then the measure should not apply. There is no reason to make any risk adjustment. For example please consider the following:

- if the disabled population is only adults, then none of the measures specific to children would apply, or
- in the non-disabled population, there may not be a large enough population with COPD for the COPD measures to be valid, therefore this measure would not apply.

d) 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?

We propose the twenty-five (25) measures listed above. These measures cover the spectrum of preventive and health promotion services, management of acute conditions, management of chronic conditions, and outcomes. This should cover the entire spectrum of care for all populations.

e) What percentage of total payment should be specifically tied to quality measures?

We recommend that two percent (2%) of the premium revenue payment to the insurer be tied to the quality measures.

f) How can the Department most effectively work with other payers to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?

Most of the measures described are already required for the current managed care organizations in either or both of the disabled and non-disabled populations. Other payers who may want to service this population also typically capture these quality measures.

These measures are almost all HEDIS standards, which have clear parameters to identify potential members for the measures and standards to determine compliance rates. HEDIS compares the results of all Medicaid plans to each other and standardizes the results. The comparative results are based on the percentage of Medicaid plans that have met or exceeded a specific compliance result.

The measures should be adopted early in the process so all providers will have time to implement processes to capture and/or improve these rates.

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

The quality measures listed above cover a broad spectrum of services and are a proxy of quality for preventive and health promotion services, and successful management of acute and chronic conditions for all populations and across medical and behavioral health conditions. Success would be achieving the 75th percentile of the applicable HEDIS measures (better rates than 75% of the all Medicaid plans).

For the one non-HEDIS measure, the percent of live births at 2500 grams or more, a standard would need to be based on current Medicaid births and the success target should be some percentage of improvement, based on the results in other comparable states.

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

Questions for Comment:

a) 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?

Based upon our experience with the Medicaid population, there are special characteristics of this population that require elevated attention in order to address poor outcomes and increased costs. These include social issues, mental health issues, and higher emergency room utilization. Studies have also shown that Medicaid recipients who have co-morbid diagnoses and chronic disease also tend to have higher costs due to lack of coordination in their care.

To that effect the minimal communication requirement for providers should include:

a. The ability for mental health and medical providers to share information freely
b. The ability of the primary care provider to provide to the Medicaid recipient a summary of their care inclusive of medications, recent tests, providers and plan of care
c. On the inpatient side the hospitals should provide written legible, preferably typed, discharge summaries within 24-hours of discharge to the primary care provider
d. The Emergency Departments should provide to the primary care providers within 48-hrs of discharge a summary of tests done and treatment (unless patient was admitted). Additionally, communication to ensure a member is connected back to the member's medical home is recommended.
e. The primary care provider should have within every members profile a check off list that identifies tests that need to be done and when ensures that certain tests are performed

b) Should the Department offer bonuses for investments in EHR systems, above the substantial incentives from ARRA?

The Department should not offer bonuses for investments in EHR systems above the substantial incentives from ARRA. The bonuses would not drive increased utilization and would also tend to create a marketplace of varied EHR systems that would not speak to each other or to a health exchange. The Department would realize a greater return if those resources are spent on developing a health exchange platform that is able to accept information from the major EHR systems, integrate the data and have the capability of allowing the provider to their patient specific data that has been received from multiple sources such as the Emergency department, laboratories, hospitals, etc. The Department should look into the possibility of using their purchasing power on behalf of the smaller providers or groups. This group buying power would be able to offset the costs to the providers without the department incurring costs.

c) 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?)

If the Department decides to add an incentive to support electronic connectivity this incentive should be a onetime incentive focused on operational efficiency. That is are the providers submitting their encounters and other data in a format that the department and the future health exchange can utilize. This would ultimately assist the department in measuring the providers and paying any quality bonuses

d) 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?

All practices should be tied to the meaningful use requirements as stated in the ARRA.

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

a) How much risk should be necessary to qualify as risk-based?

Full (100%) risk is needed for the care coordination program to be significant and meaningful. All entities should be held to the same requirements under a full risk, capitated model. Full risk drives the appropriate efficiencies that the program would want to achieve. It would also ensure entities that are appropriately capitalized and have the necessary infrastructure to manage and coordinate care participate in the program. Additionally, all entities should be held to the same risk based capital requirements set for by the Department of Insurance. This would ensure solvency and financial capacity to manage risk, pay providers and invest in the program.

b) Could "risk-based arrangements" include models with only up-side risk, such as pay-for-performance or a shared savings model? But if it is only up-side risk, is there any "skin in the game", without something to be lost by bad performance?

Any up-side arrangements, such as pay-for-performance or shared savings should be offered only as a bonus rather than as a financing model to preclude care coordination entities from having to take up-side and down-side risk. Risk arrangements should include down-side risk.

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

While it is recommended that down-side risk is required immediately, if up-side is initially included, it should be replaced with the acceptance of down-side risk within 1 year.

d) What should be a relative size of potential payments conditioned on whether a provider is accepting full risk as compared to a shared savings model?

There should be a 10% differential in payments based on whether a provider is accepting full risk as compared to a shared savings model.

e) In the case of either a capitated or a shared-savings model, what should be the minimum Medical Loss Ratio for a provider?

A minimum Medical Loss Ratio would need to vary based on the population being included in the program. The requirement in the current voluntary program is 80% and is within an appropriate target range for a minimum MLR.

f) 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 the direct providers?

The coordinated care entity should be at risk. Any model for sharing that risk with providers should be driven through the relationships the entities establish with providers.

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

We recommend that initially risk adjustment be done on an age, sex and population basis. After time, phasing in risk adjustment on a disease incidence based methodology would be appropriate. This would provide time to ensure processes are in place with risk based provider entities to achieve 100% complete encounter and data exchange. Stop loss and reinsurance should be the responsibility of the entity to procure or self-fund. That is why RBC requirements should be incorporated into the program.

h) 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 minimum MLR is one way to ensure that risk-based payments are not used to limit appropriate care. Additionally, strict access, grievance and appeal process requirements and external review organization audits are recommended. Another approach can be similar to what the State of Hawaii has implemented as part of its QExA program. They have appointed and Ombudsman to oversee the program. This role provides oversight and is accessible to members that may have any problems with receiving the benefits under the program. This is another mechanism by which the state can assure the incentives are aligned.

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

Questions for Comment:

a) 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?

The State should follow the market and only consider proven, reliable and sustainable models of coordinated care.

b) What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements?

The NAIC's risk-based capital (RBC) requirements should be used to develop the minimum amount of surplus needed to support an organization's overall business operations. The RBC formula ensures required capital needed to support the business in the case that certain adverse conditions occur and to ensure that the actual capital and surplus on hand is sufficient to meet both current and future needs.

How should the determination of "minimal financial base" be different for one and two-sided risk arrangements?

Both arrangements should have the same risk-based capital requirements.

Should Department of Insurance certification be required?

Yes, licensure requirements and certification standards should ensure a level playing field for all types of organizations that seek to participate in Medicaid.

c) 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?

We do recommend that there be a minimum number of enrollees per entity. While the recommendation is that there is not an option for one-sided risk, if that is part of the program, it is our recommendation that they would be subject to a lower minimum number, a lower assignment percentage and a lower total plan maximum enrollment. The number or enrollees should not be different by client. We also recommend that any established relationship with a care coordination entity by a member not be disrupted. A minimum enrollment level does allow for an entity to achieve the economies of scale needed to manage risk and devote the administrative and clinical resources. One way to achieve that is to limit the number of entities participating in the program. This can be done by ensuring that only risk bearing, appropriately capitalized and clinically capable entities are considered for inclusion.

d) What primary care or access to specialty care should be required?

A multi-disciplinary team approach is essential. As outlined in under question 1, this multi-disciplinary approach incorporates the medical home, contracted network of providers and clinical care manager around a member centric theme to care coordination. There should be a ratio of primary care providers for number of assigned members. This ratio should be adjusted based on the population served. Specialty care should be required to meet time and distance standards and appointment availability standards. This will ensure there is enough specialty capacity in addition to members not having travel times as a barrier to care. The time distance standards should be adjusted for rural, urban and major metro areas.

How extensive should be the network of providers to be able to offer access to a full range of care?

There should be extensive networks of primary care physicians, safety-net providers and specialists working to devise and follow care plans that address the full array of patient needs. As stated above, sufficient capacity should be available across all provider types. There needs to be some consideration for certain provider types where there is a shortage in available providers.

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

Individuals with special health care needs are members who have, or are at high risk for, chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. We believe that these members would benefit from intensive care management and interventions tailored to address their chronic conditions.

6. What should be the requirements for client assignment?

Questions for Comment:

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

We would not recommend limitation by underlying medical conditions. The care coordination entity should be responsible for integration and coordination across all provider types and all medical conditions.

It is possible to exclude clients with underlying medical conditions. It is imperative that the entities that would be responsible for managing these clients with certain conditions share data and information on a timely basis and work in partnership in coordinating care of individuals who have co-occurring conditions that are the responsibility of another entity. This communication and relationship is important, and failure points in the relationship could cause clients to not receive the appropriate coordination. A design requiring clients to select a different set of providers for the underlying medical condition is possible but not recommended.

b) 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?

We recommend stratification at a minimum to a county level but more appropriately to a regional level with an opportunity for a care coordination entity to provide services at one or multiple county / regions on through a statewide presence if capable. Because of the distribution population in Illinois, any entity wishing to participate in an area that includes the greater Chicagoland counties / region, then they should be required to have a presence in more rural counties / region(s).

Absolutely a provider should have coverage throughout a major area, such as Chicago.

The program should not be stratified down to a neighborhood level. Stratifying to such a granular level would create complexity. There would be too many different options to navigate for clients; providers would have to have multiple contractual relationships they have to manage; you would lose the ability to drive economies through a smaller group of participants; where service areas and neighborhoods start and end can be difficult to manage; the Department would have to manage and provide oversight to multiple organizations; and the most effective programs have utilized a limited number of entities to manage a broad geography . These are just a few of the reasons to keep stratification at a higher level.

c) 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)?

It is recommended that there be no limitations on eligible populations. A care coordination entity should be responsible for all populations and should have the capability, network, and programs to manage the individual needs of each member.

d) On what basis should assignment of clients who have not self-assigned be made in the first year?

If a client has not self-selected, assignment in the first year be based on a "round robin" methodology among approved participating entities.

e) One approach would 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-assigns. What are the strengths and weaknesses of these approaches? Are there other approaches?

Strengths of auto-assignment to capacity in proportion to self-assigning choices include the following:

- Probable alignment between network size being the cause of higher self-assigns and therefore greater capacity to handle a higher percentage of auto-assigns.
- Rewards plans that attract members on a voluntary basis with higher auto-assignment process

Weaknesses of auto-assignment to capacity in proportion to self-assigning choices include the following:

- If multiple geographies included in an auto-assignment catchment area then voluntaries in a high population area may skew auto-assignment in another geographic area
- Does not account for disenrollment rate. Ability to keep members can be a more important aspect of capability
- A proportional auto-assignment rate in an environment with low overall voluntary selection rate may not yield the desired result

Strengths of bidding on slots:

- Allows the program to achieve savings by aligning highest auto-assignment rate with PMPM cost buy down through bid

- Potential to receive best bid from the most clinically efficient plan
- Potential to receive higher bids from more resource rich entities

Weaknesses of bidding on slots:

- Potential to "buy" membership without consideration of network capacity or program capability
- May not continue established physician relationship if process looks past previous PCP relationship
- Winning bid may be a result of undercutting managed care plans whose rates would better cover state-mandated services to Medicaid beneficiaries
- Uneven market share distribution may result with provider rate decreases in negotiations from greater membership leveraging

Additional approaches include higher auto-assignment based on quality scores, based on PCP panel capacity, outcomes driven assignment, administrative measures, member satisfaction scores, or based on provider match in the entity's contracted network. These are all other approaches that the program could evaluate and use.

f) 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 methodology that incorporated these elements immediately could be beneficial. However, in recognizing that some entities need to develop the experience with the program, the recommendation would be to migrate to a more experience based process in 18 months. This would allow for 12 months of data and 6 months of run-out on claims and ample time for a measurement period to get a complete picture.

g) Whether for self or auto-assignment, should there be a lock-period? If so, for how long? What safety mechanism should exist for clients where stringent enforcement of the lock-in would be detrimental?

There should be an annual open enrollment period and a lock-in period as well. The recommendation is for an annual one month open enrollment period (OEP) each year and the remaining 11 months would be the lock-in period. For new members assigned, they would have an open enrollment period for the one month immediately after their enrollment month and then would have another option wherever in their tenure the annual OEP falls.

Like in the Medicare program, there should be a member initiated special election period (SEP) that allows them to make a plan change outside of the OEP in those cases where they can request a change for a Good Cause reason through an appeal to the Department.

h) If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?

The Department could select a discrete population as part of the demonstration project. This could be based on geography, such as county, or eligibility based, such as all TANF eligibles or all dual ABD clients. After that selection, members would receive a letter from the Department indicating the mandatory program with appropriate background on the participating entities with messaging that they have 90 days to choose a plan and if they do not, that they would be auto-assigned into one of the participating plans in days 91-120. Each of the plans would have 60 days to lead time to send information to members that are enrolled during this process, from ID cards through explanation of benefits and programs. The program could then begin on day 181, for a total of 6 months lead time.

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

An integrated solution for dual-eligible members is vitally important. To achieve the best coordination for this vulnerable pollution, coordination by the same entity for both Medicaid and Medicare services should be required. For this reason, the Department should mandate that any program participants be required to also offer Medicare programs and services if they want to serve this segment of the population. The Department should at a minimum allow dual-eligibles enrolled with an entity for Medicaid to also enroll in the same plan's Medicare product, if not enrolled in the plan's Medicaid and Medicare product as part of an integrated solution for both Medicaid and Medicare services.

The importance of coordination among providers, regardless of network and payer, is well understood but difficult to achieve. Provider offices must devote significant time and energy to managing care across networks and plans rather than focusing on the holistic needs of the patient. Without integrated solutions, plans would have to devote significant time and resources to improving coordination of care to the extent possible under the current system. However, the lack of a single medical home and quality improvement process for dually eligible members inhibits the potential for true integration. The overall system also is vulnerable to poor clinical coordination as well as cost shifting between Medicare and Medicaid when members are not enrolled in a single plan.

Health information challenges resulting from the current, two-path delivery system for dual-eligibles are well documented. Members do not have access to complete medical records and program policies from a single source; providers must adhere to separate enrollment, claims submission and reporting requirements; care coordinators frequently need to rely on members and providers to report diagnostic information and services; payers must invest resources in coordination of benefits; and state policymakers lack ready access to complete service utilization data to monitor quality of care.

These are just some of the reasons why coordination by a single entity, and more specifically one that integrates across both Medicaid and Medicare, is the best solution for clients.

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

Questions for Comment:

a) 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 which Medicaid is their only coordinated care contract.)

Continuity of care is the cornerstone to member quality, but historically it has been most at risk when members lose eligibility (addressed below in section 7b) rather than when entities come and go or change contractual status. In the past, when entities have left the Illinois market, there were concentrated efforts by both the remaining plans and HFS to keep members with their medical home and the members' associated network of specialists and hospitals. If this should occur in the future, the same process should be followed during this transition, which was as follows:

- Member selection of insurer and medical home
- If no member selection or no time to implement a member selection process, then identification of the member's current medical home relationship
  - Assignment of the member to the same medical home, if contracted
  - If more than one insurer with the member's current medical home, reassignment to the same medical home with random selection of insurers based on family units.
  - If no insurer with the same medical home, then random selection based on medical home providers used by family members, age of member and specialty of provider, and geography

In this new environment, when there may be lock-in requirements, all members of entities who leave or change their contractual status should be allowed to change medical homes, either member-selected or assigned, within three months of the date of the entity change.

b) 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 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)?

The availability of the Basic Health Plan (BHP) will greatly facilitate continuity of care and will help to address churning of consumers in and out of different coverage options as income changes. This is of particular for concern for low-income adults and their families. Historical research demonstrated that 43% of newly enrolled adults in Medicaid experience a disruption in coverage within twelve months.[1] More recent modeling suggests

[1] Sommers BD. 2009. "Loss of health insurance among non-elderly adults in Medicaid." *J Gen Intern Medicine,* 24(1):1–7.

that 35% of low-income adults will experience a change in eligibility within six months and 50% will experience a change within one year. Of particular concern is that 24% will experience at least two eligibility changes within a year, and 39% will experience such churning within two years.[2] For adults with children, these income fluctuations may also affect child eligibility for various programs.

Churning inhibits a health plan's ability to appropriately implement case management, quality improvement, and evaluation strategies. It also has adverse effects on access to care and administrative costs. Even frequent changes in health plans, with no gaps in coverage, can present detrimental problems. Therefore, it will be to the greatest benefit for low-income individuals to have access to a health plan that can provide Medicaid, CHIP, and BHP coverage. The BHP, an option which networks of traditional Medicaid providers will be able to handle, will permit continuity of care using a provider network with historical experience in providing care to this population. This will help adults retain coverage and keep families together, which could result in greater enrollment, more stable coverage, and fewer coverage gaps by mitigating program churn due to income fluctuations.

From a consumer perspective, the BHP will be more attractive than using tax credits or subsidies to purchase what will likely be higher cost coverage via the Exchange. Furthermore, low-income individuals may reject the use of subsidies in the Exchange, for fear of owing money to the Internal Revenue Service at the end of the year if their annual income turns out to exceed what they anticipated when subsidies were paid during the course of the year. The BHP provides these individuals with a quality health coverage product without the possibility of having to reconcile thousands of dollars at the end of the year.

c) 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?

The rules of the Exchange should not require that all insurers offer plans in both Medicaid and the Exchange. Depending upon how the Exchange is ultimately structured, and particularly if Medicaid is heavily integrated in the Exchange, such a requirement would preclude plans with a mission, specific expertise, and provider networks capable of providing high quality, cost-effective care to low-income populations, from serving in the Illinois Medicaid market.

While such a requirement may appear to be a solution to churning, it could in fact exclude plans which have the most sophisticated knowledge and experience in working with low-income populations from participating in your State market. As such it could increase churning and administrative burdens rather than alleviate such concerns. This approach would likely compromise access to services and quality of care for the State's most vulnerable citizens.

Based on the latest guidance, which is expected to be updated shortly, we recognize the special circumstances of low income populations that would participate in Exchanges. There will be substantial churn between the Exchange and Medicaid programs – and the population below 200% of the FPL is typically uninsured and often

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[2] Sommers B and S Rosenbaum. 2011. "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. *Health Affairs*, 30:2, 228-236.

times have children in a SCHIP program. Entities that traditionally serve low-income folks are uniquely qualified to play a significant role in the Exchange. It is our opinion that Medicaid plans that meet federal exchange requirements should be presumptively approved to participate in the Exchanges – based on the plans experience in meeting the needs of low income populations and the fact that the majority of Exchange participants will be low or moderate income.

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

Members should have the right to continue the medical home relationship during changing circumstances, as long as the medical home provider contracts with the new insurer and accepts the new insurer reimbursement. If the medical home provider is unwilling to contract with the new entity, or accept the reimbursement based on the members' changing circumstances, then existing transition of care requirements should be followed:

- Continuing care with current medical home providers for up to 90 days should there be no alternative provider or ability to transition complicated care within that timeframe.
- Continuing care with current obstetrical providers for up to 90 days and through delivery if the member is in the third trimester of pregnancy.
- Continuing care with current specialist providers for longer than 90 days if there is a medical or psychological reason to continue, such as completion of a course of chemotherapy or radiation treatments, ongoing surgical complications that require additional surgical procedures, or a high risk pregnancy.

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

The statistically valid CAHPS survey should be made mandatory to all entities. The CAHPS survey is used by NCQA to validate member perception of different quality aspects of many insurers, is used to compare insurers to each other for specific populations (Medicaid, commercial and Medicare), and is the industry standard of member satisfaction and perception of quality. This survey is so prevalently used in the industry that it accounts for a large percentage of the points used towards NCQA accreditation. Although the CAHPS study should be paid for by the entity, it must be conducted by an independent agency to eliminate any potential bias.

Members should also be allowed to appeal any service denial and entities should be required to investigate any expression of member dissatisfaction through a formal member grievance process. Additionally, there should be a mandatory review by the entity of potential quality of care concerns identified through adverse outcomes or member complaints.

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

<u>Questions for comment:</u>

a) ***How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care network or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't sure your organization would participate, what would be some of the factors impacting your choice?***

We anticipate participating as a directly contracted entity providing comprehensive services to all populations at full (100%) risk.

b) ***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 your serve? If so, please share it.***

We currently participate in the Voluntary TANF program in the State. We would utilize the same model with the necessary adjustments needed for serving the different populations that may be part of an integrated program. Our robust clinical platform and model, contracted network, and infrastructure are in place today and are serving members.

c) ***Is your organization considering developing a Medicare ACO? Do you see opportunities like ACO's in the private market? How do you see yourself involved in either Medicare or other forms of ACOS?***

We currently participate in Medicare with a suite of Medicare Advantage plans. We have the capability to integrate both the Medicaid and Medicare products on an integrated basis. Our plan has experience in coordinating and taking financial risk for both Medicare and Medicaid. Specifically in Hawaii, we have enrolled members in The QExA program who receive Medicaid benefits from our plan through our state contract into our Medicare Advantage plans. The State of Hawaii has allowed for provision of all services from one entity by allowing them to enroll in their Medicare plans if they are offered. We have worked with the State on the potential to pursue a fully integrated plan where the entity is responsible for both Medicare and Medicaid services. Providing care for the dual eligible members on an integrated basis provides cost effectiveness, member satisfaction, better coordination, and the ability to drive higher quality and outcomes.

d) ***If your organization is considering participating in Medicaid coordinated care in some way beyond contracting with coordinated entities, do you think you will be ready to do so by mid-2012? If not, when?***

Not applicable

e) 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?

We have great deal of capacity to take on additional Medicaid clients. Our capacity varies by geography. Because we participate in the voluntary program, we already have established networks in parts of the state including Cook County. We can take an additional 200 thousand members today, and could further expand our capacity through contracting efforts as needed. In those areas we don't have a plan, our expertise to build networks and engage providers to work with us gives us the unique ability to expand as needed.

We are also capable of and have experience in of serving all populations. Whether TANF, ABD, HCB, institutional or disabled, our clinical model and experience extends beyond any one particular group. We are suited to take on coordinated care responsibility for all clients.

End of Comments from Harmony Health Plan of Illinois

Again, we appreciate this opportunity to provide our comments, and look forward to continued dialogue with your office on these and other issues critical to the success of the reform efforts. If I can ever be of further assistance and a resource for you, please do not hesitate to contact me directly at (312) 516-5144.

Sincerely,

Sanjoy Musunuri
Region President
Harmony Health Plan of Illinois, Inc.