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To: Illinois Department of Healthcare and Family Services

From: Judy Smythe, SVP, General Manager
McKesson Health Solutions LLC
Via Electronic Submission: hfs.webmaster@illinois.gov

RE: Illinois Coordinated Care Program

On behalf of McKesson Health Solutions (MHS), I would like to thank the Illinois Department of Healthcare and Family Services (HFS) for the opportunity to comment on the Coordinated Care Program currently under consideration. As a partner of HFS for the past five years on the Your Healthcare Plus™ (YHP) program, we have seen Illinois establish itself as a leader in Medicaid, looking at new and innovative approaches to controlling costs and improving quality. At MHS, our approach to Care Management is based upon a foundation of care coordination, and we believe it is critical for the vulnerable Medicaid population.

In reviewing the discussion document provided by HFS, it appears HFS is considering many potential solutions, including provider-based models and managed care. We agree there are many different approaches to addressing the need for care coordination, and we urge HFS to consider all options.

With a national focus on Accountable Care Organizations and accountable care in general, it is only logical that HFS would be considering provider-based models. We strongly support the concept of the Patient Centered Medical Home (PCMH), and we support this model as part of our Care Management solution. The successful YHP program in Illinois was based on a medical home model, where our staff worked directly with providers and patients to ensure care was coordinated through the medical home. We believe a PCMH model is the best avenue to long-term success; however, it is important to recognize it will take a great deal of infrastructure change on the part of HFS and providers to reach the envisioned end state. A PCMH model will evolve over time as inherent issues within the current health care system are addressed. Some of the current issues include:

1. Reimbursement: Care coordination requires appropriate reimbursement approaches and rates that offer health care professionals the funding to provide care coordination as part of their medical home model. Without reform of the current methodology for reimbursement,

maintaining the resources to provide care coordination is unsustainable. There were numerous grant-based pilots employed that allowed provider practices to secure PCMH certification, but when grant money ended, many of the resources added were dropped. Further, without addressing reimbursement and payment delays, the state will likely continue to see a decrease in providers willing to see Medicaid patients.

2. Cost of care coordination: Although there are considerable long-term fiscal benefits for care coordination within a medical home, up-front costs that are often borne by medical providers are not reimbursable. These costs add up to a substantial and sometimes unrealistic sum of money for most primary care practices.

3. Limited access to technology resources: Often providers have limited or no access to health information technology to facilitate care coordination, and necessary technology environments are not coordinated across different medical sites. Further, new technologies that do not fit into the normal work flow of a practice are often not used as intended.

4. The need to address cultural diversity: Increasing cultural diversity in the populations served exacerbates the challenges of providing resources, materials and outreach staff to make a difference in the care of the patients most in need.

As a partner to HFS for the YHP program, we identified strategies to work with Illinois providers in addressing the above issues. Without addressing these critical issues, a care coordination program cannot begin to improve quality of care and achieve cost savings. We recognized that the medical home must serve as the hub for care coordination and our efforts focused on developing strong provider relationships and providing critical data and resources in a timely and actionable manner. With 170 YHP staff members located throughout the state, we were able to establish these provider relationships, in some cases integrating YHP staff into a practice. By providing clinical metric reports and chart reminders to providers on a quarterly basis, providers were able to take action on this data and work with their practice staff to close gaps in care.

Looking at other potential solutions, we are aware of the trend toward Managed Care in many states. With the complex nature of Medicaid and state budget issues, Managed Care can be appealing as a short-term fix. We have seen successes with Managed Care, but only when a state recognizes the need for rigorous oversight and checks-and-balances to address quality. As stated in the HFS discussion document, Managed Care has evolved over time, and it is important to recognize the best practices that have been established. These best practices include a focus on quality, measurement of HEDIS metrics, measurement of provider and patient satisfaction, the inclusion of the high-risk ABD population, and a prohibition on “cherry picking” covered populations.

Illinois is just beginning its journey into Managed Care for the ABD population with the launch of the Integrated Care Program. This program will serve approximately 25% of the state’s ABD/waiver participants in the Collar County geographies. It will be important to closely monitor the launch and

outcomes of the program to assess overall performance over time. Many providers and patients have concerns about Managed Care, which are based, in general, on past experiences. This fact emphasizes the need for focus on the above best practices, the continued importance of the PCMH (which should still serve as the hub for care coordination), and a transfer of lessons learned from the YHP program to any subsequent managed care program.

With the above in mind, we would like to respond to some of the specific questions included in the discussion document.

Question #1: How comprehensive must coordinated care be?

Regardless of the ultimate solution(s) deployed, we agree the provider's role as the medical home is key to successful care coordination. While a requirement for full NCQA certification may not be feasible, it is still important to identify key requirements that will be expected of a medical home to address patients' care coordination needs. HFS should consider changes to the reimbursement system and must address issues with prompt payment to allow providers to commit the resources needed for care coordination.

Through our work on the YHP program, we have first-hand knowledge of the complexity of this population and the challenges providers will face in meeting their needs. A solution for care coordination must focus on the total population, recognizing that it will have to address a spectrum of risk profiles (from low to high risk). There should be consistency throughout geographies, addressing Illinois' mix of dense urban and rural populations. For example, in the YHP program, care teams were distributed over 24 statewide catchment areas, ensuring staff lived and worked in the communities they served. The care team utilized creative outreach strategies within each community (e.g., working with shelters, churches, and local providers) to locate and engage patients. In order to properly stratify this population and identify the care coordination service needed, the role of analytics cannot be overlooked. MHS and HFS worked together on robust analytics to evaluate the YHP program over the past five years. When designing provider-based or managed care models, the same level of rigor should be employed.

Question #5: What structural characteristics should be required for new models of coordinated care?

Illinois has traditionally been a leader in the Medicaid space looking for innovative approaches to controlling costs and improving quality. That trend should continue; Illinois cannot afford to wait and follow the market. With the end of YHP on June 30, 2011, 75% of the ABD population in Illinois was left without a formal care coordination process. While Illinois Health Connect remains in place for the majority of these patients for the next year, we believe most providers are not in a position to act as a PCMH today. A third-party Care Management organization can be utilized in various ways to ensure providers have access to the tools, resources, experience, data, and technology required to successfully address care coordination. There is a lot of momentum resulting from the YHP program, and it is our hope that Illinois would leverage lessons learned by quickly deploying a care coordination strategy.

A successful care coordination program must employ holistic-person management, addressing both the medical and behavioral health co-morbidities. It must be a population approach, but with the flexibility to manage individuals uniquely, based on their needs and care plans. The majority of the most vulnerable patients will reside in the ABD and waiver programs; these individuals will require a higher level of care coordination support. In the YHP program, social workers were assigned to work with high-risk individuals if they frequented the emergency room or as they transitioned out of the hospital. Behavioral health specialists facilitated the necessary communication channels between behavioral health providers and medical homes. Beyond coordinating care for these high-risk individuals, it is important to analyze data that identifies these patients as they move up or down the risk spectrum.

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

All models of care coordination will require HFS oversight and the establishment of checks-and-balances. We support risk-sharing as a mechanism to help ensure quality, utilization, and financial goals are met. Risk-sharing can take several forms, each of which has its own pros and cons. Providers will expect reimbursement mechanisms and payment delay issues to be addressed; this is critical if they are taking on a more robust role in care coordination. Full capitation may appear to be a viable solution; however, it is important that HFS establish metrics to address quality outcomes and ensure access to care is not reduced. MHS operated several Pay for Performance and Provider Recognition programs in various forms and saw the value in driving improved outcomes. The provider recognition program in YHP did not include financial reward but was successful in engaging providers and driving improved clinical metric outcomes.

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

MHS supports the inclusion of evidence-based quality metrics, such as those monitored by HEDIS. These metrics are critical for measuring program performance. Providers should have a mechanism to access and take action on this data on a regular basis in order to close gaps in care. The YHP program utilized quarterly provider report data (available online and in hard copy) to identify gaps in care and worked with providers in closing them. We saw success with providers through our chart reminder program, which highlighted these gaps in an easy-to-use format. With the distribution of our diabetes chart reminders, YHP saw a 40% increase in annual lipid panel testing and a 34% increase in A1C testing. Additional measures would include utilization metrics, financial savings, and member and provider satisfaction.

Regardless of the various measures identified, it is critical that HFS work to develop a rigorous scoring methodology for evaluating program performance over time. Throughout the five years of the YHP program, MHS and HFS worked together to conduct annual reconciliations which utilized a detailed methodology to measure financial and quality outcomes. Through this process, we were able to capitalize on successes and adjust where needed in order to deliver the most value. Annual

reconciliations showed that YHP produced a net savings of $569 million over four years and improved many clinical metrics. It will be important to have a mechanism for scoring program performance over time and against other solutions.

Question #7: How should consumer rights and continuity of care be protected?

We agree that both consumer rights and continuity of care are important components to a successful program. By placing an emphasis on the PCMH, the program will be positioned to address these issues long-term. As mentioned in the discussion document, we agree there is a critical need to measure member satisfaction and create a forum for members to raise issues or concerns. YHP has relied heavily on member and provider feedback to monitor program performance and make enhancements over time. This has been particularly true over the past three months, as we have worked collaboratively with HFS to ensure a smooth transition of patients into the Integrated Care Program or Illinois Health Connect with the end of YHP on June 30, 2011.

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

As a third-party Care Management organization, we recognize the complex needs and challenges in delivering care coordination for vulnerable populations. With our industry experience and a successful five-year partnership in Illinois, we believe we have a deep understanding of the challenges of designing a long-term care coordination strategy. We recognize the need to be flexible in how our solutions are deployed, whether that be through providers, managed care, or fee-for-service settings.

Thank you for this opportunity to provide our thoughts on care coordination as Illinois defines its strategy. We consider Illinois to be a valuable partner and are proud of the successes we achieved together through the YHP program. We hope Illinois will leverage the successes and lessons learned in order to best collaborate with providers and serve needy patients. We welcome further discussions on this topic.

Sincerely,

Judy Smythe
SVP and General Manger
McKesson Health Solutions LLC