AWAKENED ALTERNATIVES ENTERPRISES
RESPONSE TO JULIE HAMOS'
STATEMENTS ON KEY POLICY ISSUES
CONCERNING THE COORDINATED CARE PROGRAM

INTRODUCTION

Illinois' new Coordinated Care Program has the potential to revolutionize the delivery of healthcare services to our society's most vulnerable citizens. Because HFS is such a significant purchaser of healthcare services, it is in a position to play a critical role in moving the provider community to the new paradigms that are needed to save our national system of healthcare delivery.

To do so, it would seem that contractual commitments to coordinate services with complementary delivery entities are essential. Contracts among the various providers help to clarify roles and obligations, as well as presenting an opportunity to think through compensation models that reward providers based upon better outcomes, not simply fees for services that are provided which may or may not benefit the patient. While we give lip service to patient-centered care initiatives, the truth is that our system is driven by the momentum of the revenue streams that have been generated by volume.

THE COMPREHENSIVENESS OF COORDINATED CARE

All integrated care programs regardless of payer source, i.e., federal, state or commercial, should require contracts with providers, entities, organizations and ancillary services to meet beneficiary needs across the life span from cradle to grave. To maximize the return on investment that can be gained through the provision of integrated, coordinated care, all providers, regardless of discipline and affiliation, must be statutorily and contractually obligated to participate in said program as a requirement for reimbursement. Beneficiary health needs change over time depending upon condition. The consequence of not having sufficient numbers of contracted providers, facilities, organizations and ancillary services to meet these needs is the risk of recreating a fragmented care delivery environment.

The core of integrated care programs lies with medical home. As such, the medical home model needs to be structured to efficiently and effectively utilize the resources contained therein. Primary Care Physicians are the gateway to care under the current healthcare delivery model as well as an ever growing limited resource. We recommend medical homes consider structuring themselves in such a manner to allow and support the primary care physician in fulfilling his or her most important responsibility, the assessment, treatment and care of the patient. This can be realized through the use of less expensive and more readily available advanced practice nurses and physician assistants empowered with prescription authority to assume responsibility for the coordination of care delivery and management of timely communications among providers. In turn, advance practice nurses and physician assistants can be supported through the use of a mix of licensed and non-licensed facility, office or organization based and field-based personnel to manage the oversight, monitoring and efficacy of care delivery within the home and community settings.

Our experience has demonstrated that the lack of field-based resources to work with beneficiaries in the home and community environments results in a crucial gap that poses significant risk for fragmented care. Many of the root causes to barriers in access to care, achieving desired outcomes and successful transition of responsibility and accountability for the optimum state of wellness to the patient are home and/or community environment based. Thus, a combination of interdisciplinary brick and mortar, telephonic and field-based care providers serves to strengthen and increases the likelihood that medical homes will reach their goals and objectives which are:

1. To provide time, medically necessary and appropriate care;
2. To eliminate the provision of extraneous, duplicative services;
3. To minimize the use of avoidable hospitalization and emergency room resources to treat ambulatory sensitive conditions at their lowest levels; and
4. To optimize quality healthcare outcomes, including preventive and maintenance.

We support the recommendation of the Illinois Department of Healthcare and Family Services' (Department) for medical homes to be certified. Certification is the process whereby medical home efficacy, efficiency and quality outcomes can be compared equally regardless of setting, i.e., urban, suburban or rural. A formalized certification program sets the minimum quality standards all medical homes are required to meet in

order to further validate and champion the Department's desire for integrated coordinated care delivery.

We do not recommend that one single accreditation agency's certification be required or set out as the "gold standard". Each of the major accreditation agencies, Joint Commission, the National Committee for Quality Assurance (NCQA) and URAC offers its own unique strengths and weaknesses under their Medical Home Certification Program models. It is our recommendation that the Department review the three government approved certification models, identify and incorporate the strengths of each into one reasonable, attainable and sustainable medical home certification program. For example, Joint Commission certification standards address the quintessential elements an organization needs to ensure the appropriate structures and processes are in place to support achievement of the desired care delivery outcomes. These structures and processes include the following: leadership, performance improvement, information management, human resources and medical staff, infection control, environment of care, assessment, care delivery and medication management and preservation of patient rights. NCQA certification standards address the critical financial, medical and quality management elements that medical homes need to attract and retain satisfied patients. URAC certification standards address patient right protections that may lend well to ensuring patients receive fair and equal treatment from their medical home. Accreditation agency certification in and of itself does not ensure integrated care delivery or outcomes. Rather, accreditation agency certification programs set equal standards by which a medical home's care delivery and outcomes can be measured, evaluated, reported and compared across a "level playing field" regardless of urban, suburban and rural settings. This "level playing field" is pertinent and important given the geographic distribution of the current Medicaid member population.

Recognizing this type of review and subsequent collaboration to facilitate buy-in, consensus and agreement on the application of these strengths takes time, we support the Department's recommendation of a time-limited, phased in certification approach.

Moreover, mandatory accreditation agency certification adds to the administrative burden that practices and medical homes must bear. To off-set this additional burden, we support the Department's recommendation to provide "some kind of umbrella coverage for entities" as an incentive to participate in the program and to decrease

pharmaceutical, supply and other operational costs. The Department, given the magnitude of services it provides, offers enormous opportunity to leverage its economy of scale to secure large volume pharmaceutical, supply and other operational service discounts that would incentivize providers to participate in its integrated care program.

HEALTH CARE OUTCOMES AND EVIDENCE-BASED PRACTICE MEASURES

Patient outcomes and associated cost-savings are paramount to the success or failure of the Department's integrated care program. The quality measures by which performance is measured, evaluated and compared must be:

1. Carefully chosen;
2. Measurable with a quantified and defined numerator and denominator;
3. Clearly defined and reflective of the care delivery outcome they are intended to measure;
4. Applicable to the entire patient population regardless of setting; and
5. Relevant to the intended goals and objectives of the program.

We recommend that no more than 20 quality measures be selected to reduce the administrative burden of data collection, analysis, evaluation and reporting on participating medical home providers.

The nature and content of these measures should be relevant and specific to the age and type of beneficiaries and conditions managed by the medical home. We advocate the inclusion preventive and maintenance care measures as well as measures that demonstrate a positive decrease in the use of redundant services, avoidable hospitalizations and unnecessary or inappropriate emergency room utilization. We support the the inclusion of NCQA's HEDIS measures and Joint Commission and CMS' core measures as applicable.

We support the Department's desire for client risk-adjustment in order to level the playing field among providers and the wide range of situations they manage. However, risk-adjustment poses the risk of being a double-edged sword. To mitigate this risk, we recommend that any risk-adjustment methodology used be applicable to all

beneficiaries and providers and include as many objective data elements as possible to minimize untoward skewing of the results.

To further incentivize providers to participate in the integrated care program, providers whose quality of care delivery adheres to nationally recognized evidence-based guidelines and yields the desired positive outcomes should receive higher rates of reimbursement. We support the use of two pay-for-performance reimbursement models: gain-sharing and performance withholds. Under each model, a proration of the providers' reimbursement is withheld and placed into a pay-for-performance pool. Providers then have the opportunity to earn that money and/or more depending upon their outcomes meeting or exceeding the desired quality outcome benchmarks. This way providers have "skin in the game" without being placed at further, larger risks of financial loss in an already low reimbursement environment.

Quality success can be defined in a myriad of ways. We advocate the assessment and achievement of integrated care coordination goals be measured longitudinally over a predefined period. We recommend the following quality measures be considered as benchmarks for measuring and identifying at which point success of the integrated coordinated care program has been achieved:

1. The rates of duplicative or avoidable repeat services among providers has been eliminated or significantly reduced, including, but not limited to: provider visits, outpatient radiology and laboratory testing, diagnostic procedures and medication use.
2. The rates of preventive and maintenance quality measures is attained and sustained at the 90th percentile in accordance with HEDIS.
3. The rates of avoidable hospitalization and unnecessary or inappropriate emergency room service use declines and are maintained at their goal use levels over time.
4. The continued increased rates of successful treatment of ambulatory sensitive conditions and corollary continued decrease in avoidable hospitalizations to treat said conditions are maintained over time
5. The rates of on-set, progression, exacerbation and relapse of controllable medical and behavioral health conditions, or combination thereof, are in a steady state of decline over a long period of time.

ELECTRONIC INFORMATION CAPABILITY REQUIREMENTS

Dr. Jonathon Perlin, MD, National Committee on HIT Standards leader and former Under Secretary of Health for Department of Veterans Affairs, states the need for required electronic information capability requirements using the following analogy:

> "Why can an individual who purchases a car in New York and locks their keys in the car in California be able to have the doors unlocked by calling one number yet the same individual whose doctor's office is 3 or 4 blocks away from the local hospital emergency room cannot get timely access to their vital health information?"

The analogy underscores the importance of electronic medical information exchange in the Medicaid integrated coordinated care program. All providers, regardless of discipline, setting or organization, should be required to implement electronic health records. These electronic health records, regardless of vendor, should be accessible, to the extent permissible under federal and state HIPAA and other confidentiality laws, to treat patients. This accessibility is critical to the elimination of redundant, extraneous and unnecessarily duplicative delivery of care services, especially in the areas of outpatient imaging, laboratory testing, diagnostic testing and medication management.

All providers, regardless of setting, facility or organizations, should be incentivized through enhanced reimbursement, bonuses and participation in federal and state subsidy programs. Currently, provider subsidy and participation bonuses are limited to physicians, medical practices and hospitals. This is not enough. Integrated coordinated care is dependent upon the timely of exchange of medical information among all providers, including, but not limited to: laboratories, non-physician practice free-standing ambulatory facilities, home health, long-term care, pharmacies, etc. Integrated coordinated care does not imply or specific to instances of medical home and hospital care. Truly integrated coordinated care spans the breadth of the beneficiary's life cycle and changing needs.

The electronic exchange of medical information within Medicaid program is not enough. We advocate for the inclusion and integration of commercial and Medicare information into the Medicaid program due changing dynamics. The face of the Medicaid beneficiary is rapidly changing from the stereotypical "person on welfare" to

the uninsured and unemployed through job loss, the uninsured or under-insured due to personal financial collapse, the uninsured or under-insured who are not able to afford commercial healthcare coverage due to low wages and those eligible under the Affordable Care Act legislation.

Payment for provider participation subsidy and bonus expansion as well as inclusion of commercial and Medicare data may be off-set through use of any one the following:

1. Cost savings gained through the reduction and elimination of redundant, duplicative services.
2. Cost savings gained through the increased treatment of ambulatory sensitive conditions in the appropriate setting.
3. Cost savings gained through declining avoidable hospitalization and unnecessary or inappropriate emergency room use.
4. A reimbursement reduction to providers who choose not to implement an electronic health record.
5. A reimbursement reduction or non-payment of medically unnecessary, inappropriate or avoidable redundant services performed by providers who had access to electronic health record information but did not access such information prior to performing the service.
6. Non-payment of common redundant medical services, such as outpatient diagnostic imaging and laboratory testing within a certain period of the initial service.

We advocate a phased-in timeframe for the adoption and use of electronic health records in accordance with applicable state and federal law and state requirements.

COORDINATED CARE RISK-BASED PAYMENT ARRANGEMENTS

The success or failure of integrated coordinated care programs is not entirely dependent upon risk-based payment arrangements. Rather, we believe the success or failure of the integrated coordinated care program is contingent upon a) gaining provider support, buy-in and participation and b) a total reimbursement paradigm shift.

To incent providers participation in the Medicaid integrated coordinated care program, reimbursement as a whole needs to be revisited and restructured, especially if mandatory beneficiary enrollment into a managed care organization is required.

Under the current Medicaid reimbursement structure, providers have no real incentive to contract with managed care organizations, regardless if TANF or AABD, because the rate of Medicaid reimbursement is the same.

Under the Medicaid integrated coordinated care program, we recommend this current payment structure be changed in such a way that providers who choose not to participate in the Medicaid integrated coordinated care program or contract with Medicaid TANF or AABD managed care organizations receive a lesser ate of reimbursement for services. This reimbursement change is necessary to financially persuade all providers, across all disciplines, to participate in and collaborate under the Medicaid integrated coordinated care program.

Once providers are contracted to participate in the Medicaid integrated coordinated care program and/or with Medicaid managed care organizations, we believe a balanced capitated risk-based payment arrangements are appropriate. Capitated risk-payment arrangements, when properly structured and balanced, do not deter or pose barriers to care. Rather these types of arrangements foster more provider accountability and responsibility for their care delivery and outcomes in the following ways:

1. Providers have “financial skin in the game”;
2. Providers get a sense of the finite limitations of healthcare reimbursement;
3. Providers develop the skills they need to be more judicious and prudent in how capitated monies are allocated to ensure the care services delivered drive desired outcomes;
4. Providers are intrinsically incentivized to adhere to evidence-based practice guidelines to avoid unnecessary expenditures; and
5. Providers will be incentivized to collaborate with one another to eliminate the cost of or risk of non-reimbursement for avoidable duplicative services.

We also believe that under capitated risk-based payment arrangements, providers need sufficient protections from outliers through the implementation of fair and equitable

stop-loss and reinsurance contractual provisions as well as not be expected to assume 100% risk. Most physicians, including practices and medical homes, operate in today's marketplace on razor thin margins due to ever declining reimbursement. To off-set the risk of a financial catastrophe that may result in a worsening access to care issues, both the state and providers need to negotiate tolerable medical loss ratio minimums specific to urban, suburban and rural providers.

Moreover, a clear definition of outlier needs to be established and inclusive of conditions that by nature are very expensive or complex to diagnose and treat, meet exclusionary criteria that prevent the application of evidence-based practice guidelines and conditions that arise as a result of unpreventable complications.

Careful monitoring and trending of quality outcome data, especially problematic, aberrant or downward trends, appropriate investigation of adverse, near-miss or sentinel events, and timely appropriate response to beneficiary complaints will help to mitigate the risk of capitated risk-based payments being used as disincentives to treat complex or very expensive conditions or limit appropriate care.

STRUCTURAL CHARACTERISTICS FOR NEW MODELS OF COORDINATED CARE

We believe this is an prime opportunity for the Department to become a leader in the Medicaid integrated coordinated care market and to improve its national quality ranking.

We believe entities should be held to a reasonable minimum financial base necessary to provide sufficient stability in the face of risk-based payment arrangements in accordance with Department of Insurance requirements. We agree there needs to be flexibility built into the minimal financial base as so to accommodate the differences in scope between one and two-sided risk arrangements.

We support a minimum number of enrollees being assigned to an entity to provide additional incentive of financial stability and ensure the entity has sufficient administrative resources to accommodate and monitor the integrated coordinated care program. Moreover, we believe entities need to have a sufficient network of specialty and ancillary service providers, including home care, long-term, etc., to ensure the

entity has sufficient resources to meet beneficiaries changing needs along the continuum of care.

We believe the primary care physician is at the very core of an integrated coordinated care program. As such, specialty physician access should be coordinated and monitored by the medical home to as a safeguard to prevent further fragmentation of care. One exception to specialty care access would be in the instance a specialty care physician agrees contractually to act in the capacity as a primary care physician and demonstrates the willingness to coordinate and treat the full range of the beneficiaries' health care need and not just those limited to his or her scope of specialty practice.

Special risk-based payment arrangements, minimum financial basis and minimum number of enrollee requirements should be available to entities that want to provide integrated coordinated care to particularly expensive or otherwise difficult clients, especially in urban or suburban healthcare disparate and rural geographic areas.

REQUIREMENTS FOR CLIENT ASSIGNMENT

We believe it makes sense to stratify client assignment based intensity of service delivery needs, i.e., TANF vs. AABD. This stratification is reasonable as not all medical homes are equipped nor have sufficient resources available to equally to simultaneously manage medical, behavioral and psychosocial support needs to promote optimum states of wellness.

We believe it is reasonable for the Department to expect providers and their affiliated medical homes to have sufficient network coverage within a 30 mile or 30 minute radius of their homes for urban and suburban areas in accordance with standard commercial insurance network requirements. For rural areas we recommend that primary care services be available within 30 miles or 30 minutes of the beneficiaries' homes and that cooperative specialty care agreements be in place with providers and/or tertiary centers within a reasonable distance from the members' homes. For beneficiaries who must travel distances greater than 30 miles from their home to obtain specialty transportation, we recommend economical Medicaid paid transportation be provided to reduce access to care barriers caused by an inability to pay said transportation costs.

It is reasonable to permit highly specialized entities which are proficient, highly skilled and competent in managing subpopulations such as TANF, AABD, children with special health care needs and serious mental illness limit the eligible population they serve. The specific sub-populations often require a different level of core competency and expertise to successfully manage. Moreover, beneficiaries included in the sub-populations often have long-term patient relationships with these providers and to disrupt or change that relationship poses continuity of care and communication breakdown risks.

We believe beneficiaries should first be given the option to choose their primary care provider voluntarily. In the event mandatory enrollment is necessary, we support a process of mandatory enrollee assignment that closely aligns with the best care option for their medical, behavioral and/or psychosocial needs as well as in close proximity to their homes.

We believe a key weakness in permitting providers to bid on slots for auto-assignment is the risk of cherry picking or purposeful discharge of an enrollee with medically and/or behaviorally complex or costly to treat diagnoses.

As the program evolves and provider outcome trends are established we support the evolution of auto-assignment to those providers whose practice adheres to evidence-based care guidelines and demonstrates repeatable positive quality outcomes.

Regardless of what methodology is used to perform auto-assignment, enrollees should be locked into their newly auto-assigned provider for the first 90 days unless a bona fide exception case exists.

We support the Department's participation in federal, state and private funded demonstration projects to further evaluate, refine and enhance the integrated coordinated care program. We recommend the Department approach these opportunities with a select population of beneficiaries who stand the gain the most from the demonstration project's end goal and objectives as the study population.

We believe beneficiaries dually covered under Medicare and Medicaid require a higher intensity of integrated care coordination services as they are often the most vulnerable, complex and costly of all the health care populations to manage.

CONSUMER RIGHTS AND CONTINUITY OF CARE PROTECTIONS

We believe coordinated and guided transitions of care carefully monitored and facilitated by field-based, licensed clinical personnel is pivotal to maintain the continuity of care, including transfer of medical information and hand-off communications. Specially trained field-based clinically licensed personal would be there to work collaboratively with the beneficiary, his or her family or other caregivers and the transferring and receiving physicians to prevent avoidable gap in care and ensure timely transfer of medical information and data.

We believe the key to preserving continuity of care among beneficiaries who go across Medicaid and other subsidized insurance programs is through the consistent availability, integrity and confidentially of electronic health record information.

We believe plans, whose business model is to offer both Medicaid and other subsidized insurance coverage under the exchange, offer and provide for transparent movement of beneficiaries across plans to preserve and maintain continuity of care as the beneficiary's income and/or circumstances change. Likewise we support similar transparency for movement between Medicaid or subsidized health plans under the exchange and commercial or Medicare insurance.

We believe clients should be afforded the same patient rights available to commercial beneficiaries to continue a medical home relationship with their provider of choice as circumstances change.

We believe all providers, regardless of payer and beneficiary affiliation, should report quality outcomes specific to the patient and in aggregate.

We believe beneficiaries, regardless of payer source, have the right to participate in the planning of their care and treatment, have a voice in decisions made about their health care and have the right to appeal decisions made by the payer and viewed by objective third parties that are in conflict or question with their healthcare wants and desires.

ORGANIZATION PARTICIPATION IN COORDINATED CARE

Awakened Alternatives Enterprises is positioned to work collaboratively and harmoniously with payers, providers, beneficiaries and their families or caregivers to ensure their health care needs, regardless if medical, behavioral or a combination thereof, using field-based specially trained clinical and non-clinical personnel.

Our model of care is patient centric. Our goal is to ensure patient medical, behavioral health and psychosocial needs are simultaneously met. It is difficult to inspire life sustaining positive behavior healthcare change and to empower beneficiaries to accept self-responsibility and accountability for their optimum state of wellness if their basic psychosocial needs of shelter, food, clothing, medicine and access to care are not being met.