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July 1, 2011

Ms. Julie Hamos
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Re: Comments Regarding "Coordinated Care Program: Key Policy Issues"

Dear Director Hamos:

The Legal Assistance Foundation of Metropolitan Chicago (LAF) appreciates the opportunity to submit this response to the Coordinated Care Program ("CCP") discussion paper circulated by the Illinois Department of Healthcare and Family Services (HFS). We focus our responses on those questions most relevant to our client population, primarily adults and children at or below 150% of the Federal Poverty Level. Many of these clients are currently receiving or in need of Medicaid, Family Care or All Kids health insurance benefits.

Section 6 - Requirements for client assignment:

First and foremost, we emphasize the importance of placing as few restrictions and limits as possible on choice for care, and access. Many of those we serve already struggle to overcome barriers of limited transportation, LEP, limited health literacy, mental illness and housing instability in their effort to access healthcare. They are highly vulnerable to any programmatic restrictions on access or choice, and awareness of that vulnerability should remain a touchstone as HFS explores policies and procedures for the CCP.

6.a: With this in mind, we disagree with any proposal to limit provider choice by medical condition. The example of limiting those with behavioral health issues to a different set of providers than other clients illustrates the problem. This client population faces some of the most complex barriers of any group to health care, and their choice of providers should be at least as great as that available to the general client population.

6.b: We also believe that our clients would be best served by providers with network coverage throughout the Chicago metropolitan area, rather than those limited by a neighborhood. Although we recognize the value of neighborhood providers that are culturally and linguistically appropriate for their patients, our clients' housing situations are sufficiently fluid, and their ability to return to previous neighborhoods just for healthcare is sufficiently challenged, that they need to be able to move from neighborhood to neighborhood without having to wrestle with continuity of care issues.

6.c: In addition to concerns about providers limited by neighborhood, we are concerned about allowing entities to limit the populations they serve. Giving this latitude, even regarding apparently benign population groups, may result in limiting access of patients with more – and more complex – medical problems, as compared to populations of lower cost patients.

6.d-e-f-g: On the question of assigning clients who have not self-assigned, it is essential that HFS closely monitor the current Integrated Care Program (ICP) being implemented in the suburban Chicago area to assess programmatic problems and successes with auto-assignment. The ICP should provide useful data regarding the strengths and weaknesses of the models being used, the single case agreement option, and client outreach regarding mandated enrollment. Any lock-in period would limit client choice. An effective appeal and fair hearing system consistent with due process, including clear and understandable notices, would help protect clients' timely access to necessary care if they are subject to a lock-in period and are experiencing access or continuity of care obstacles.

Section 7 – Consumer rights and continuity of care:

It is our general belief that the broader and deeper the provider networks, the more likely clients are to get consistent access to quality care. The challenges facing the Integrated Care Program's current effort to enroll providers may provide some insight into challenges the Coordinate Care Program could face in provider participation. We assume that HFS would work with its community partners to anticipate any provider participation challenges, and to thoroughly investigate all the legal, financial, and logistical incentives available to encourage the broadest possible provider participation.

7.b-c: We believe it is critical that providers be required to offer plans in both Medicaid and the Exchange in an effort to ensure transparent movement from one to the other as a client's income changes. Without provider overlap between Medicaid and the Exchanges, seamless transition for clients is impossible, and those clients at the vulnerable edge between periods of work and periods of unemployment will be further destabilized by frequent and confusing changes to their access to health care and providers.

7.d: If the Coordinated Care Program succeeds in placing clients into effective and appropriate medical homes, HFS should create an opportunity for clients to continue

those relationships even if a change in circumstance would otherwise disrupt them. These opportunities might include an option analogous to the single case agreement currently available in the Integrated Care Program, and other options.

7.e: Effective consumer protections for both quality of and access to care could be secured by requiring participating providers to submit encounter data as a condition precedent to payment on the set payment cycle. The encounter data would provide HFS with valuable information about access and quality of care for clients and, if made available in consumer-friendly report-card form, could provide some of the transparency that is critical to informed consumer choice at enrollment and re-enrollment opportunities, and to program monitoring.

Thank you for the opportunity to address these questions at this early stage in the development of the CCP. We look forward to future discussions and opportunities to comment on the Coordinated Care Program.

Sincerely,

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