From: Stephanie Altman
To: HFS.Webmaster
Subject: Coordinated Care
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Director Hamos,

On behalf of our clients at Health & Disability Advocates, we respectfully submit the following comments to HFS on the issues/questions posed in the Coordinated Care Policy paper. We have also submitted joint comments with Children's Memorial Hospital on the specific issues related to children with special health care needs and their access to specialty care. Thank you for the opportunity to comment.

Monitoring and Enforcement:

In particular, in these comments, we address access, enrollment and delivery system issues from a client perspective. We are not providing commentary on the questions raised related solely to providers such as those asking for comments regarding reimbursement methods; risk based contracting; and electronic billing. Overall, our interest on behalf of our clients, who range from children to adults; are generally low income; and often have disabilities and special health care needs, is to streamline their access to enrollment in health care, provide the most comprehensive services possible to meet their needs, and allow them to access providers in a coordinated fashion. Our primary recommendation in any coordinated care system, especially one in which risk is shifted to the plan or provider, is that HFS closely monitor enrollment, access and services delivered through requirements that all plans submit encounter data to the state and that failure to do so results in monetary penalties. We have learned through our experience with managed care in Illinois that access and service MCO contract provisions are generally not enforced as strongly as they should be due to lack of monitoring or lack of sanctions in the Medicaid program. Coordinated care, especially plans in which risk is shifted, are more difficult to monitor because the state does not have fee for service billing records to serve as data collection. The state must regulate plans through encounter data measured against accepted and transparent standards such as HEDIS. Such data and measurements should be transparent to the public through reporting and dissemination on the HFS website. However, if there is no enforcement or sanctions for failure to provide data or to meet standards, such requirements are useless.

Use of Federal Health Home Option and Case Management:

In general, we support the health home concept which would organize care around a central provider who can provide the consumer with medical, behavioral and social services. We believe that it is critical for the populations we serve that the medical home model be broadened to include, in coordination or through facilitated referral, social and case management services. Often it is these services that are the key element to serving the most vulnerable hard to reach populations such as the homeless and those experiencing mental illness and substance abuse problems. Medical care coordination is necessary but can be futile without adequate social and case management services to remove barriers to care such as housing, addiction, poverty, and employment. While we realize that it is not the sole responsibility of the Medicaid agency to provide social services to this population, we believe it is cost-effective and good health care to coordinate services with other state agencies such as DHS and DOA and to mandate that all private providers participate in coordinated case management to effectively serve the patient population. Thus, we specifically recommend that HFS consider implementing the new federal health home option for as many vulnerable populations as possible in order to target care coordination and case management to the safety net populations. Whether this population is served through capitated managed care or other risk or non-risk based delivery systems, health home options can be utilized to provide federal financial incentive for case management and care coordination.

Enrollment Issues:

Illinois has a long and mixed history with capitated managed care. Learning from our past experience is key to making sure that clients have access to primary and specialty care; adequate choice of providers; and the flexibility to maintain current care relationships if appropriate. We believe the key to enrollment

is to phase in enrollment slowly enough to ensure that there is enough time to educate consumers about their choices. Even in the best education enrollment system, there will be a percentage of the population which defaults into care. Therefore, we recommend liberal no cause policies for changing plans and providers in the first six months of any mandatory enrollment system. After six months, we recommend an unlimited time to change plans and providers if cause is presented. Historic problems with provider participation in managed care networks mandates that enrollment should be slow enough to ensure access and that provider networks must be closely monitored by the State. The state should specifically monitor specialty care networks and referrals due to the historic access problems with specialty providers. Due process appeal rights should continue to remain the primary responsibility of the state to ensure that there is adequate oversight and avenues by which clients can appeal from decisions made by coordinated care entities even if such entities provide their own appeal and grievance processes.

Long Term Care Services and Supports Measures:

We also support the use of specific measurements for disabled populations to include data collection on successful transitions from LTC facilities to home and community based care. Care coordination should include LTC transition and waiver programs to maximize access and to save funding dollars. In particular, health homes can be used to direct services to populations in institutional care to facilitate transfer to HCBS care. Federal dollars can be combined with other transition programs such as Money Follows the Person and waiver programs to maximize funding for services such as case management, housing and employment, which are often key to maintaining health in the community.

Implications of the ACA, Medicaid and Basic Health Programs after 2014:

Ideally, we would support a coordinated system by which Medicaid recipients who have income that fluctuates above and below the Medicaid and exchange subsidy levels will be able to maintain their provider relationships as they move; however, we realize that this will be a difficult task primarily because managed care plans may not be able to create and maintain a network that consists of providers who will accept Medicaid reimbursement and insurance reimbursement. If the state can maintain reimbursement rates equal to rates paid by the participating insurance companies and plans in the health care exchange, it will encourage Medicaid provider participation at the same level and facilitate continuous care relationships.

Thank you for the opportunity to comment. We look forward to participating in hearings and committees to further plan care coordination in Illinois.

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