Julie Hamos
Director
Illinois Department of Healthcare and Family Services

Dear Director Hamos:

Sinai Health System appreciates the opportunity to comment on key policy issues that should be considered as the State of Illinois develops a coordinated care program. We would like to suggest the following priorities:

1. The development of coordinated care models should ensure that there is access to an adequate delivery system of care, both geographically in the communities where Medicaid patients reside, and for the full scope of services that Medicaid patients require. Patients should have access to community based services, pre-primary care, primary care, specialty care, inpatient care, rehabilitation services and other post acute services. We believe that such access is critical not only for the provision of care, but for preventing readmissions and controlling costs.

2. Coordinated care should utilize community interventions to improve health status and control costs. Sinai Health System has developed a model of "pre-primary care" which utilizes community health workers to go into the homes of patients with chronic diseases to identify and resolve issues which may be affecting their condition and ultimately leading to emergency room utilization and inpatient admission. Our asthma pre primary care initiative greatly reduced rates of emergency room utilization and inpatient admissions. We believe that this model, incorporated into a coordinated care program, could dramatically reduce costs and improve health status ($1.00 spent on community worker avoids up to $14.00 of acute spending).

3. We urge the Department to support provider sponsored initiatives such as managed care community networks to provide coordinated care for Medicaid recipients. Family Health Network, sponsored by several safety-net hospitals, has been a successful managed care model.

4. We agree with the Department that quality initiatives should be part of a coordinated care program. However, we urge the Department to follow the Medicare federal example of testing quality measures over a sufficient period of time through a demonstration before incorporating them into a payment model. Sinai participated in a multi-year quality demonstration project with the Centers for Medicare and Medicaid Services and the Premier Hospital Alliance. That demonstration project played a major role in assisting the federal government to design its quality program for Medicare. Because Medicaid measures may be different, we urge the Department to begin with a smaller demonstration project and then incorporate well tested measures over a period of time.

5. We also suggest that the Department should consider testing different approaches for distinct populations. For example, we suggest that the Department look at active participation of physiatrists (physical medicine and rehabilitation) in the management of coordinated care for patients with disabilities.

In addition to the above general goals, we would like to provide specific input on the issue of electronic health records as it relates to the Department's questions.

To what extent should electronic information capabilities be required?

The state and federal governments are strongly committed to the concept that all medical practice in the 21st century needs to operate in the context of an electronic health record that, in some degree, is connected to all other providers. But that is not the current situation. Even the progress taking place and anticipated in response to the incentive payments created by ARRA will not result in universal electronic coverage and information exchange in the near term. Accordingly, it would be unrealistic to require these capabilities initially, even though we expect material progress from the current situation by 2013.

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?

While HFS could require providers in a Coordinated Care Organization (CCO) to make use of NwHIN Direct technology for secure messaging during the early stages of CCO deployment, actual use will be hard to measure (beyond simply requiring all providers to report their NwHIN Direct address). HFS may be better served to send a clear signal to the provider community of expectations that, on a future date (in 2013- 2015), providers participating in CCOs will be required to use EMR systems and participate in health information exchanges. This will give providers a clear sense of direction to guide investment decisions and provide time to implement such systems.

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

No. The ARRA incentives are probably sufficient to fund the acquisition of EMR systems for those providers willing to implement them. What is lacking is a business model to support on-going use of the systems and particularly, the use of information sharing technologies such as health information exchanges. HFS would be best served by providing financial incentives to CCO arrangements that include connected providers who exchange information to deliver care. Rates paid to CCOs should provide an incentive to make use of health information exchange technologies to encourage their use. Initially, the payment incentives may have to be for adoption and use of the technologies. As they become more mature, CCOs could be rewarded for result achieved using the information exchange.

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?)

The question is not inducing connectivity but rather sustaining it once installed (which also provides an incentive to install the technology). HFS should provide financial incentives for the ongoing use of electronic connectivity. While it would be unfair to provide differential payment rates until providers have had adequate time to implement connectivity, connectivity probably won't occur unless providers can see a clear requirement that their use will be required and that use will be supported financially. So HFS should make clear early in the roll-out process for CCOs that use of electronic connectivity will be required in the future (2013-15) and spell out the financial incentives that will be paid in the future (2013-15) so that providers can make investment decisions that will enable them to connect in time to take advantage of the incentives. It should be noted that the incentives should encourage use of regional Health Information Exchanges which are better suited to optimizing the delivery of local care. ILHIE – the Illinois Health Information Exchange – is likely to serve as an exchange of exchanges – a transport hub linking the various regional HIEs together rather than serving providers directly.

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?

For physicians (and hospitals) that focus primarily on the Medicaid population, there are no penalties for not participating in the move to EMRs and electronic health information exchange – just a missed funding opportunity. The only penalties are imposed by the Medicare program so for those providers who have minimal Medicare activity the incentive to implement is diluted. HFS has an opportunity to motivate earlier adoption by providing a financial incentive through CCOs for providers to implement EMRs and connectivity. The other factor that will influence adoption is the current wave of physician practice acquisition/consolidation. This will have the affect of accelerating the adoption process – but the timing is hard to predict. Rather than establish new requirements, HFS should conform to the requirements and standards established through the CMS EHR Incentive program (ARRA/Meaningful Use). Creating different standards would create confusion, delay and expense. It would make more sense for HFS to create financial incentives for use of the technologies and for results achieved by using the technologies. For example, HFS could provide incentive payments to CCOs that have a certain percentage of their members who have successfully attested to Meaningful Use or who are active participants in an HIE. Such measures might evolve over time to include percentage of patients whose lab/xray results are available to all providers in the network via an HIE. HFS should build on the measures used to attest to Meaningful Use as a way to measure adoption of EMRs and exchange of health information and should

use the market forces created by incentive payments to pull provider adoption in the desired direction.

Thank you for the opportunity to share our input on the development of coordinated care in Illinois.