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**To:** [HFS.Webmaster](#)  
**Subject:** Coordinated Care Comments  
**Date:** Friday, July 01, 2011 6:44:40 PM  
**Attachments:** [Coordinated Care Program SIH cmmnts.docx](#)

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Please see the attached documents with SIH's comments. Thank you for this opportunity.

## Coordinated Care Program – Southern Illinois Healthcare Comments

### **1. How comprehensive must coordinated care be?**

*Coordinated Care entities should be able to provide an integrated delivery system across the state. HFS accurately acknowledges that it is “difficult to offer the same delivery system on the 87 rural counties” but it is shortsighted in focusing on the more densely populated areas. It has been our experience that a number of Medicaid members residing in urban areas travel to or have dependents living in southern Illinois (primarily college students). These individuals will not receive coordinated care if the coordinated care entity cannot provide a state-wide network and share medical record information among all its providers regardless of urban or rural location.*

*A standardized medical home model based on NCQA guidelines would allow for more consistent care and outcomes measurement and reporting. While NCQA Medical Home certification would not necessarily be a requirement, those that do seek it should be rewarded for their efforts through an add-on payment or some other financial incentive. Models that deviate from nationally recognized standards would lead to inconsistencies in care, reporting, and performance evaluation as well as create an undue burden on providers, particularly those who have already built models based on NCQA standards.*

*Financial combined with “administrative” incentives would more successfully incentivize providers to join Coordinated Care entities than financial incentives alone. Shared savings (initially up-side only); add-on payments for medical home management and practices serving a disproportionate share of Medicaid members; higher base fee schedules for providers and grants for EHR adoption and/or hiring of care coordinators (or other types of clinical staff to help facilitate the goals of coordinated care) would be meaningful financial incentives. Other types of incentives that would be of great value to providers are: elimination of pre-authorization/referral requirements; elimination of or reduced number of Medicaid RAC audits (audit criteria should also be adapted to coordinated care model); guaranteed prompt payment within 30 days; time limits on retrospective audits; and more current and reliable eligibility information.*

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

*Utilizing established outcomes measures (i.e. HEDIS, PQRI, CMS Core Measures) would promote standardization and efficiency without creating an unwarranted burden on providers. However, some of these established quality measures focus more heavily on primary care than specialty care; as a result, HFS should consider adding measures that can apply equally to all types of providers such as: e-prescribing, generic drug usage, or participation in patient safety or education initiatives.*

*The percentage of total payment tied to outcomes should start small (i.e. 10%) and gradually increase over time unless the coordinated care entity has the support of its providers to assume greater risk. Coordinated Care requires a substantial investment of time and money by providers and it can require years to not only become fully operational but to see any meaningful results.*

### **3. To what extent should electronic information capabilities be required?**

*Real time sharing of medical record information is a critical component to the success of coordinated care, therefore, an EHR or some form of electronic work around (i.e. manual data entry into a web based disease registry) is most desirable.* Grants or subsidies could be offered to providers with paper practices in order to facilitate adoption of an EHR. Financial incentives (such as higher base pay) for those using EHRs and integrating them if multiple EHRs exist within a coordinated care entity, would also encourage adoption of EHRs.

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

*Pure risk (capitation) should not be utilized by coordinated care entities or their contracted providers unless they have demonstrated experience with this methodology without issues.* Multiple risk options should be available to providers with at least 2-3 years being allowed for payment under and up-side risk contract before movement towards full risk. HFS must consider that in some areas (mainly rural) there may not be enough lives assigned to the coordinated care entity to allow for certain types of risk contracting and any form of risk payment may drive some providers to stop accepting Medicaid members. In these areas, performance based bonuses would be a more reasonable initial payment methodology.

#### **5. What structural characteristics should be required for new models of coordinated care?**

*Recommended structural characteristics for new models:* demonstrated financial stability, demonstrated network stability (adequate numbers of providers in all areas of care – I. PCPs, specialists, hospitals, long-term care, pharmacy, etc.); no record of frequent entrance into and pulling out of markets; fast and efficient claims processing systems compliant with HIPAA transaction requirements; able to share claims data electronically with providers; resources (human and electronic) for assisting providers with care coordination; and demonstrated experience in pay for performance.

#### **6. What should be the requirements for client assignment?**

*The coordinated care entity or provider's ability to take on new capacity as well as their clinical performance should be considered before auto-assigning members.* By considering both criteria, HFS can ensure low performing entities/providers do not get all the auto-assigned lives. Providers must retain the ability to close their practice to new members, however. Once assigned (whether by choice or auto-assignment) the member should be locked in for a year similar to private insurance (exceptions could be allowed for changing PCP). The goals of coordinated care (higher quality, lower cost) cannot be achieved if the member is allowed to change "homes" during the year. Delayed care, gaps in medical record information, and unreliable eligibility information will result.

#### **7. How should consumer rights and continuity of care be protected?**

*HFS may create and require adoption of standard contract provisions governing:* coordinated care entity rights and responsibilities; non-discrimination; hold-harmless; transition of care (including

medical record information); and duties upon termination that would help protect members' rights and promote continuity of care.

*Ideally, a central data warehouse or functional statewide HIE where all Medicaid member information could be retained and shared with all providers would ensure that member information was always available to the provider or coordinated care entity assuming the member's care.*

**8. What is your organization's preliminary anticipation of how it might participate in coordinated care?**

*SIH is currently developing a clinically integrated physician-hospital organization (PHO) that adopts many of the characteristics of ACOs and medical home models, however, until the anti-trust risks of forming an ACO are addressed (and safe harbors created) and, unless CMS requires ACO members to receive all of their care within the ACO in order for it to be covered, SIH will not form or participate in an ACO or like organization of independent providers. This PHO will likely consider contracting with Managed Medicaid plans so long as (at a minimum): HFS ensures multiple plans are offered in the southern Illinois market to ensure competition; capitation isn't mandated; and these plans are able and willing to share claims data electronically and provide resources (financial and human – must be local too) to providers.*