Coordinated Care Program Responses

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1. How comprehensive must coordinated care be?
a) Do you think that coordinated care should require contracts with specific entities that arrange care for the entire range of services available to a client via Medicaid, across multiple settings and providers? Are there any alternatives you would recommend for consideration?

The contracting should include specialties such as podiatry. Podiatric physicians are the primary physicians for the foot and ankle and are crucial in keeping people active and in those individuals with impaired circulation and/or diabetes. Podiatrists are the most qualified physicians to effectively treat the foot and ankle based on their education, training and experience. Patient access to the best possible providers is very important for cost containment.

b) Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time, i.e. start with a base set of requirements and gradually increase over time?

We believe that the elements should be required as an integral part of the entity or made available on a contractual basis.

d) How explicit should requirements be about how an entity achieves coordinated care? For instance, should the care coordination entity be required to assign an integrator or care coordinator to each enrollee?

The program should look to outcomes. Too rigid a structure does not allow for innovation; over regulation leads to system overload and deferring effective care for patients. Most important is patient access to care, freedom of choice and outcomes. Too often, the delay in referrals leads to excessive costs associated with the wrong type of provider attempting to treat foot and ankle problems.

e) Where, if at all, should HFS provide some kind of umbrella coverage for entities, e.g. negotiate a master pharmaceutical contract that would be available to all coordinated care entities?

Yes, any way to keep down the cost of providing service without harming patient care should be utilized.

f) What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?

The state will need to ensure more providers are willing to accept Medicaid as so many more patients will be placed into the Medicaid system. Paperwork for coordinated care may be a consideration and should be kept to a minimum to encourage provider participation. And of course, financial incentives work best. If one is incentivized to reduce costs they tend to be more efficient.

Many podiatric physicians currently are hesitant to be a part of Medicaid due to the very low reimbursement in our state. Illinois Medicaid is one of the lowest and slowest in terms of reimbursement in the country.

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

a) What are the most important quality measures that should be considered?

Too many measures are subjective. Some form of objective based evaluation is needed to have significant improvement. Both physician and patient responses should be included in evaluating success of treatment. An appropriate measure of outcomes would include the length of time for resolution of the problem. These could also include how long it takes to get an appoint, the waiting time to see the provider, reasonable resolution and cost.

b) Is there one set of measures that should be applied to all coordinated care or might there be different measures for different kinds of clients--for instance, children versus adults or disabled versus non-disabled?

Measures should be tailored to demographic and disease related outcomes.

c) How should the Department think about client risk adjustment in order to level the playing field as providers deal with patients across a wide range of situations?

Without some risk adjustment there would be a tendency to try and shift outliers to other groups.

e) What percentage of total payment should be specifically tied to quality measures?

25%

g) How will we know when we have achieved care coordination, i.e. how should we measure success?

Use realistic outcomes. In some chronic conditions an 85% improvement may be considered a success.

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

a) 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?

Initial and progressive reports should be required to primary providers. Reports should be mailed, faxed or emailed.

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

Many providers who take care of the Medicaid population are individual providers with limited means to institute EHR's. A slow movement to EHR should be allowed. Beside the costs, many of the providers are older and are more resistant to change and fear a reduction in productivity involved in switching.

c) 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?)

Switching to EHR inevitably causes a reduction in productivity. Incentives offset the price of the system and the reduction in productivity. This must be balanced against the total cost of implementing a new system.

d) 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?

The use of EHR should coordinate or lag behind the Federal Medicare System. The system should allow for those who will or cannot switch.

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

The Medicaid reform law is clear that risk is a key component of coordinated care. Capitated payments paid to traditional managed care organizations are obvious; however, the law is not specific as to whether coordinated care entities need to assume 100% of the risk and other risk-based arrangements might be considered. The Department is mindful that provision of efficient, high quality care is most determined by the people closest to providing that care, and providing appropriate incentives is the best way to fully engage them in focusing on outcomes. We understand, however, for many providers this is a challenge to current operations.

a) How much risk should be necessary to qualify as risk-based?

Risk assumption is necessary to stimulate cost reductions. Excess risk that could cause an entity to close and walk away must be avoided. Risk that is controllable by good patient care will avoid the disastrous results of some medical groups in the 1990's.

b) Could "risk-based arrangements" include models with only up-side risk, such as pay-for-performance or a shared savings model? But if it's only up-side risk, is there any "skin in the game", without something to be lost by bad performance?

The majority of the incentive should be pay for performance. Having some negative consequences is also a motivation. Some individuals may be satisfied with the base salary and feel the effort to go up the next level is not worth it. Accessing penalties for bad performances can alleviate this situation.

e) In the case of either a capitated or a shared-savings model, what should be the maximum amount of "bonus"? Stated differently, what is the minimum Medical Loss Ratio for a provider?

15-25%

f) Who should be at risk? Is it sufficient that the coordinated care entity accepts risk, or must there be a model for sharing that risk with direct providers?

Direct providers should be at risk by way of a small hold back, not to exceed 5%.

g) How should risk adjustment be included in the model? Conversely, how should "stop loss" or "reinsurance" programs be incorporated?

A risk adjustment is necessary to avoid the dumping or under treatment of more seriously ill patients.

h) How can the state assure that capitated rates or other risk-based payments are not used to limit appropriate care or serve as a disincentive to diagnose and treat complex (i.e. expensive) conditions?

Outcome studies are necessary to offset the risk of under treatment.

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

a) Should Medicaid lead or follow the market? Should we contract only with entities with operational, proven models or should we be willing to be an entity's first or first significant client?

Be open to a portion of new providers and models as long as they meet the operational elements of the program. Innovation may improve the system, but failed innovation can ruin a system. Use proven providers for the bulk of the system with enough new providers to allow for innovation.

The program should allow for providers that are not hospital based. Most podiatric physicians are independent practitioners in private practice.

d) What primary care or access to specialty care should be required? How extensive should be the network of providers to be able to offer access to a full range of care?

Open access to primary care and timely access to specialists should be required. This includes Podiatric Medicine in both groups depending on condition. Delay of early treatment by the most qualified provider in many cases causes a more chronic condition that can be more difficult to treat. This leads to poor outcomes and additional costs.

e) Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

Yes.

6. What should be the requirements for client assignment?

a) The Medicaid reform law requires that clients have choices of plans, as do federal regulations. Would it make sense to limit the choices of clients by underlying medical conditions? (For instance, can all clients with specified behavioral health issues be required to choose among a different set of providers than clients not so identified?) Is this practical?

Although there may be treatment advantage to limit selection by disease, it would not be practical due to geographical and other considerations.

It is important that clients understand the type of plan they are entering in. Many patients do not understand what their plan allows for.

b) How much should the Department stratify choice areas by geography? Considered alternatively, would a provider need to have network coverage throughout a major area, such as Chicago? Or could a coordinated care entity limit its offerings to a particular neighborhood?

Given the difficulty for many individuals to commute to distant treatment sites, centralized or regionalized treatment centers are preferred.

c) Can entities limit the eligible population they serve, and how narrowly can they limit their population? (Can providers, for instance, limit themselves to AABD or TANF populations, or even more narrowly, such as children with complex medical needs or individuals with serious mental illness)?

Specialty areas that require particular expertise may be best located in centralized regional areas with consideration made for at risk populations.

d) On what basis should assignment of clients who have not self-assigned be made in the first year?

Geographical

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

b) Although not strictly a coordinated care issue, how can continuity of care be maintained for low income clients across Medicaid and other subsidized insurance programs--such as will be provided by the Health Benefits Exchange under the ACA? In that respect, how important to continuity is a Basic Health Plan (a provision in the ACA that allows States to create a plan for clients with incomes between Medicaid eligibility and 200% of the Federal Poverty Level)?

d) What rights, if any, should the client have to continue a medical home relationship in changing circumstances?

Continuity of care is important and as such arrangements should be made to continue a treatment plan and provider until a satisfactory replacement can be made. Whenever possible the replacement should be satisfactory to both the entity and the patient.

e) What mechanisms should be required to obtain client information on an ongoing basis about plan quality? What appeal rights might be necessary?

Follow-up should be obtained by phone or entry/exit interview. Appeals should be handled by individuals with a state supported ombudsman program.

Thank you,

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