Social Service Organizations As Coordinated Care Entities Under P.A. 96-1501

Comments of Trinity Service, Inc. and AFSCME Council 31

Introduction

In June 2011, the Illinois Department of Healthcare and Family Services ("Department") issued a request for input on key policy issues with respect to the Coordinated Care Program mandated by P.A. 96-1501, which mandates that 50% of all Illinois Medicaid recipients be in coordinated care by January 1, 2015.

This paper is in response to the Department's invitation to stakeholders to provide written comment in response to a long list of policy questions. These comments do not attempt to answer all policy questions, but seek to focus on the intellectually/developmentally disabled Medicaid population that live in facilities such as ICF-DDs and CILA group homes where they currently receive some significant degree of health care management by nurses and other trained medical professionals, including coordinating care with the individual recipient's primary care physician. Below we address the first and fifth questions in the document "Coordinated Care Program Key Policy Issues".

1. How comprehensive must coordinated care be?

Care coordination, for this population, must be comprehensive if it is to be successful. **The organization that currently provides a comprehensive array of services for these individuals is clearly in the best position to function as the care coordinator for this population, because they already "provide for or arrange for the majority of care."** And, they can do more effective care coordination if their inclusion is a formal, explicit part of the new Medicaid coordinated care program.

This may seem at odds with the common understanding of a "patient-centered medical home" centered at a medical practice. But the reality is that while physicians are not normally on the full time staff of ICF-DDs or CILAs, provider agencies that operate such residential placements have longstanding relationships with facility residents and with their families and guardians. By contrast, patient-centered medical homes rely for the most part on doctors who examine patients and give instructions to patients and to care coordinators. It is the care coordinators that interact with patients and, where necessary, with their families or guardians. Care coordination provided by staff of a residential facility will inevitably be more comprehensive than care coordination provided by a managed care company over the phone, or through care coordinators that only visit a facility on an occasional basis.

As DHFS states in its Key Policy Issues paper, the new program "does not preclude, however, organizations that offer comprehensive services or care management for people with specific diseases or conditions working with other entities serving a broader population….medical homes will be required components of coordinated care, but by themselves will not be sufficient to meet the requirement of accepting responsibility over all services."

These provider agencies already have in place the rudiments of care coordination. They are in a better position to assure compliance with a specific requirement that entities providing a coordinated care program assign a specific individual to function as a care coordinator for each Medicaid enrollee.

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

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

Yes, special arrangements should be made to accommodate expensive or otherwise difficult clients, and many of these recipients are concentrated in the intellectually/developmentally disabled population.

The Department clearly recognizes this necessity as it is already well down the road with the pilot "Integrated Care Program" for the elderly/disabled population of approximately 40,000 Medicaid recipients in suburban Cook and the collar counties. DHFS has contracted with two managed care organizations that have spent months struggling to put together sufficiently robust provider networks to handle "Phase 1" of the pilot program, which covers medical services.

Now, under P.A. 96-1501, the rest of the intellectually/developmentally disabled population will be targeted for the coordinated care program. Yet most managed care organizations do not have the experience needed to meet the unique needs and challenges of providing medical treatment and behavioral services to the I/DD population. There are few examples of private HMO's successfully implementing such a comprehensive model. And given the fragility of many of these individuals, the consequences of failure could be quite devastating.

For this reason, other states have looked to a model of integrated services that relies on their own developmental disabilities agencies or divisions to manage and oversee the medical and support needs of the I/DD population, and contracting with provider agencies for care management. An alternative model would rely on large managed care organizations which would contract with provider agencies to do this work. The intent of both models is to reduce the costs and improve the quality of medical services for the targeted population by creating a medical home for all those individuals presently funded through DHS-DDD.

State Agency/Provider Agency Model

The premise of this model is that the Developmental Disabilities Division of the Department of Human Services (DHS-DDD) would serve as the State agency which would manage the overall system of care, including any managed or integrated care. This approach would ensure the continuity of person-centered values, utilize the knowledge of present leadership staff, and finally and importantly redirect the allowable profit margins of managed care corporations to services for those un-served individuals on waiting lists and quality improvements system-wide.

One of the most advanced examples of the state agency model can be found in the State of Arizona. These comments draw considerably on the "Arizona Long Term Care System" ("ALTCS")[1], referred to here as the "Arizona model".

The Arizona model is a program for delivering health and medical care services and long term supports to the state's Medicaid eligible I/DD population. These services are provided through Arizona's Department of Economic Security, Division of Developmental Disabilities ("DES/DDD").

Using Arizona as a possible paradigm for Illinois, DHFS as the State Medicaid agency would enter into an inter-agency agreement with DHS-DDD. DHS-DDD would be the state agency that functions as the managed care organization for the health and medical care services. To accomplish this, the Department could contract directly with providers to function as care coordinators. It is important to recognize that

Illinois has in place a highly-evolved network of nonprofit community-based agencies who have decades of experience in providing comprehensive services to the I/DD population.

In addition, utilizing DHS-DDD to oversee the full spectrum of services for the I/DD population will provide continuity of care.

Managed Care Entity/Provider Agency Model

Many providers of supports to the I/DD population are already pursuing ways to bridge the gap in care through integrated and coordinated models of health delivery. Progress has been hampered by lack of funding for clinical staff, especially nursing staff. These providers fear that coordinated care provided by capitated managed care companies operating completely outside the wrap around supports already in place would be ineffective and perhaps even counter-productive. DHFS should bear in mind that many in this population cannot effectively participate in their own care management, and successful care management will require the participation of existing service providers.

Instead of capitated managed care entities acting from the outside to provide care management, a better approach would be for such entities to contract with existing providers and provide the funding to allow the further refinement of care management practices and models currently in place within the Illinois developmental disabilities service delivery system.

Provider Agency Role

Ideally, HMOs employ evidence based medicine, which involves using research findings on the effectiveness of various practices to help make treatment decisions for patients. Using this approach, medical guidelines are established. The best HMOs also use the “Centers for Excellence” approach, in that the more a healthcare provider, such as a hospital, does certain procedures over and over again, the better it will be at doing those procedures. Many HMOs, however, build their networks based on the lowest cost providers.   HMOs typically use primary care physicians as “gatekeepers” to manage access to specialty care, and these physicians often are required to get approval of a utilization review department or vendor. Thus, in reality, case management and quality assurance end up being the responsibility of the primary care physician.   The lack of medical guidelines specific to the I/DD population, combined with the unique medical needs of this population, means that HMOs and the primary care physicians they normally utilize do not have significant experience providing appropriate medical care to this population.[2]

In both of the models above, the intent is to install and further implement effective care management measures with those systems stakeholders who know the client the best-- the community-based service providers. Medical care management is built on a foundation of assessment, planning, service linkage and advocacy. The overarching goal is to increase a person’s quality of life while reducing the total health care costs of the system. A concomitant goal is to decrease fragmentation and duplication of care across health care settings and address service over-utilization. For those with identified medical needs, an agreed upon treatment plan would be established including the development of contingencies in the case of treatment or service complications. Providers who do not meet the conditions or requirements of medical care management, or do not apply, would be required to contract with an Approved Provider for medical care management services.

Under this proposal, in the event DHS-DDD were to contract directly with providers it would function as the MCO for the defined I/DD population.   While that model provides the greatest continuity of care for the target population, a private Managed Care Organization model could also require that provider act as and are reimbursed for care management.

Providers of I/DD services in good standing with DHS-DDD would be eligible to apply to become an “Approved Provider” for the persons under their care in either day or residential services. As an Approved Provider, such providers would contract to provide the following services: case management, utilization review, quality assurance, continuous quality improvement and training the contracted provider network. Approved Provider(s) would be required to employ registered nurses to function as the “Medical Care Manager”. In addition, the requirements to be an Approved Provider would be designed to ensure that the Medical Care Manager(s) have the tools and qualifications necessary to provide high quality supports along with person-centered principles in the most cost effective manner.

To be an Approved Provider, the provider would need to comply with requirements specified by DHFS including, but not limited to, staffing and support requirements. In addition, specific staff/client ratios would be established along with the requirement that the provider follow customary care management guidelines.

From time to time DHFS would assign to the Approved Provider(s) those providers who choose not to become an Approved Provider or do not meet the established requirements to be an Approved Provider.

The Medical Care Manager(s) responsibilities would include training/educating those providers on how to use the managed care system properly in rendering quality care in the most cost effective manner to the defined I/DD population. By understanding the unique needs of the defined I/DD population, the Medical Care Manager(s) would train such providers on the most efficient methods for providing services in a timely and cost effective manner (such as who is the proper provider to render care under the circumstances). In addition, the Approved Provider(s) would work with DHFS to establish systems to capture relevant data for benchmarking purposes and to further develop and refine proper medical care guidelines to use for the defined I/DD population.

Provider Network and Services

With this approach, provider networks could be developed in a variety of ways, e.g., employing Medical Care Manager(s), State Operated Medical support Centers (SOMC’s), federally qualified health centers (FQHC’s), and hospital based networks.

A. Employment of Medical Care Manager(s)

One model would be for Approved Provider(s) to employ registered nurse(s), functioning as Medical Care Manager(s) who would be responsible for individual and system outcomes, as well as the development of wellness and prevention programs. Efforts would emphasize a “self health care” approach and also include established quality management programs. For those with identified medical needs, an agreed upon treatment plan would be established including the development of contingencies in the case of treatment or service complications. The registered nurses would be required to comply with the requirements established for this model by the proposed new partnership between the Department and DHS/DDD.

B. SOMC's

A second model would be State Operated Medical Support Centers (SOMC's). SOMC's could be opened in the defined geographic area. The locations would be convenient to transportation centers and be established in size proportionate to the number of the defined I/DD population. The goal would be to include dental as well as medical services.

The SOMC's would provide the services of primary care physicians encompassing basic care while providing specialty medical services through a well organized referral network. The primary care physicians would maintain overall responsibility for managing the care of each member.

C. Federally Qualified Health Centers

A third model that could be utilized by Approved Providers of Medical Care Management Services for person with I/DD is to link these individuals to local clinicians already familiar with the specific challenges of this population. This is already occurring.

The Association for Individual Development in Aurora ("AID") has been working with a Federally Qualified Healthcare Center ("FQHC"). FQHCs are primary health care clinics which serve Medicaid recipients at an enhanced, federally subsidized rate to attract physicians to work with low income populations. All persons with disabilities are eligible to receive FQHC services, including those individuals with developmental disabilities.

AID is partnering with a local FQHC to serve as the primary care medical home for its clients. AID is moving to enroll all willing AID clients in the FQHC clinical services. Where no FQHC exists, the advent of healthcare reform and its emphasis on this service delivery model will provide opportunities for new development. And in other areas, the state service delivery system may allow community providers to access some of its resources to provide a medical home.[3]

D. Hospital Networks

A fourth model partners an Approved Provider with a local health care provider. Little City Foundation has just opened an on-campus primary care clinic and dental center for use by the 300 individuals it supports. Northwest Community Hospital ("NCH") partnered with Little City to open the Center for Healthcare and Wellness as prevention-focused services to avoid costly and traumatizing hospitalizations. NCH and Little City renovated and equipped the Center, and an NCH Advanced Practice Nurse will run the Center under contract with Little City. That person will be clinically supervised by a NCH physician. Little City will employ a dental hygienist, and NCH will refer volunteer clinicians to Little City.

Anticipated Benefits and Outcomes

- Encourage Cost Efficiencies While Delivering Care Tailored to I/DD Population

Several community providers operating under contract with the State of Illinois have undertaken initiatives to increase quality of services while reducing costs and excessive service utilization.

The Approved Providers selected by DHS-DDD under this proposal would encourage the use of the current cost containment methods that have proven effective. Additional data would be gathered based on the experience of providers. As experience in best practices is gained from the service delivery system, such measures would be applied to quality improvement across the whole system.

One example of an innovative approach to cost containment and quality improvement currently in practice is the use of the "Head-to-Toe" Assessment along with the "Signs and Symptoms Checklist" tool. Trinity Services, for example, like many providers interested in quality improvement, uses this approach for each individual. This allows Trinity direct care staff, and each resident's health care provider, to track and communicate emerging signs and symptoms of health changes. The list includes abnormal behaviors; eating/weight concerns; pain; sleep; skin and nails; ears/eyes/nose; mouth; breathing; stomach and bowels; legs/feet/toes/walking; genitourinary issues. This quality improvement approach has been very effective at spotting issues early and avoiding the need for emergency room visits and hospitalizations. Early detection is a very cost effective method and can best be performed by trained staff with day-to-day contact with the targeted individuals.

- Wellness Efforts

Significant improvements in health can be attained by adopting preventative measures, such as weight control and nutrition instruction, exercise programs and smoking cessation. DHS-DDD could build in financial incentives for Approved Providers that adopt such wellness efforts.

- Reduction in the Number of Emergency Room Visits through Use of Utilization Review

By tracking emergency room visits, data would be obtained to benchmark what is and is not appropriate for emergency room usage. Medical Care Managers would help develop the unique medical guidelines applicable to the defined I/DD population, such as, certain circumstances under which it may be more appropriate to go to an urgent care center instead of an emergency room; when a telephone call to a registered nurse ("RN") is appropriate, e.g., if it is not a life threatening situation. Medical care guidelines for the defined I/DD population would be developed based on the concept of the "right provider, at the right time, at the right place, for the right cost".

- Transportation costs could be reduced

It is anticipated, that with increased access to available providers, such as specialists like endocrinologists, in the defined geographic area, transportation costs would be reduced for medical visits.[4]

- CILA Nursing Capacity

An outcome of this initiative would be an expectation that the number of nurses would increase in CILA programs.

Why DHS-DDD Should be the Managed Care Organization ("MCO")

DHS-DDD understands the unique issues involved in rendering care to persons with I/DD. The advantages of using DHS-DDD as the State agency for managed care for persons with I/DD include:

- DHS-DDD has the administrative capability to manage and oversee quality and appropriateness of services for the State;
- By overseeing the managed care component of services, DHS-DDD would reap benefits of greater cost efficiency and improved health and social outcomes while capturing the cost-saving. to enable DHS-DDD to serve additional individuals and improving overall supports;
- DHS-DDD would serve as a central repository of information and guidance on accessing available services;
- Efficiency of a single funding stream;
- A fixed point of accountability for managing all service dollars;
- A person-centered planning process; and
- Rendering services in a timely manner reducing/eliminating the waiting time for necessary services.

Conclusion

Community providers operating under contract with the State of Illinois to support individuals with developmental disabilities have already undertaken initiatives that have sought to increase quality of services while at the same time reducing cost and excessive service utilization. Rather than risk the loss of these programs under Medicaid Managed Care, we request consideration of DHS-DDD as the Managed Care Organization ("MCO") for the defined I/DD population. Regardless of that choice, we strongly encourage DHFS to ensure that qualified I/DD provider agencies will be contracted to act as care managers for this vulnerable and unique population.

Endnotes

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[1] See: the website of the Arizona Division of Developmental Disabilities at: www.azdes.gov/ddd/. The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. Individuals must meet certain income and other requirements to obtain services. Specific information concerning ALTCS can be found on the AHCCCS website at: www.azahcccs.gov/ such as reports on cost sharing report, health care provider assessments, hospital inpatient outlier claims report, quality assessment and performance improvement strategy, and performance measures.

> According to the ALTCS Member Handbook 2009:
> "ALTCS is the Arizona Long Term Care System that provides acute and long term care services under federal guidelines and federal funds.
>
> The federal Medical Program contracts with the Arizona Health Care Cost Containment System ("AHCCCS") to provide a managed care system, part of which is ALTCS. AHCCCS in turn contracts with the Department of Economic Security/ Division of Developmental Disabilities ("DES/DDD") to deliver ALTCS services for eligible people with developmental disabilities."
> See: the ALTCS Member Handbook 2009, page 1:
> https://www.azdes.gov/CMS400Min/InternetFiles/Pamphlets/pdf/PAD-465english.pdf)

[2] HMOs frequently use resources like the Milliman's Health Cost Guidelines™ to estimate expected claim costs and model health care utilization. According to Milliman, more than 100 insurers rely on their "proprietary methodologies and comprehensive data, compiled from published and unpublished, private and public data

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sources, to adjust national average healthcare costs for specific geographic areas, benefits, reimbursement structures, and plan characteristics." However, comprehensive data as it relates to the I/DD population is clearly lacking. DHS-DDD is in the best position to collect and use the comprehensive data necessary to establish cost containment methodologies.

In addition, HMOs typically also review pharmacy costs and look at ways to reduce these costs. However, with the I/DD population, clinical practice guidelines would need to be appropriate specifically for this population.

[3] A significant percentage of persons with I/DD have a dual diagnoses, meaning they have been diagnosed with both a developmental disability, i.e., mental retardation, cerebral palsy, epilepsy or autism AND mental illness. These individuals are particularly difficult and costly to serve. What typically has been happening is when such individual's mental illness escalates and they have to be hospitalized, the hospitals stabilize them with medications and discharge them back to the facility. There is no follow up and, as a result, these individuals need to be re-admitted time after time. In some cases, the hospitals refuse to readmit them, claiming there are no available beds. Most psychiatrists do not know how to deal with dually diagnosed individuals. Federally Qualified Behavioral Health Centers could be developed.