From: Abate, Mary Ann
To: HFS.Webmaster
Subject: The Coordinated Care Program Comments
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1. How comprehensive must care be?
   Questions for comment

   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?

Coordinated Care with contracts is needed to facilitate delivery of the right health care services in the right order, at the right time and in the right setting. Care coordination is for the purpose of ensuring deliberate intentions of providing appropriate delivery of health care. It is logical to assume a contract should be developed with primary care physicians to integrate specialist services as needed including behavioral health. A contract would spell out the organization of patient care activities between participants. Organizing care usually involves sharing of personnel and other resources for patient care, which a contract would define.

   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?

All elements of care may not be available at the time a contract is formed: however, primary care and behavioral health must be integrated from the onset. Other specialists can be added over time.

   c) Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operational zed? Would existence of a medical home require NCQA certification? Would all primary care physicians be required to be in practices that meet these requirements? What requirements are essential for every practice? Presumably it would be possible to increase requirements over time. What progression would make most sense?

Rather than medical home, a person needs a "health home". No wrong door approach should operationalize the health care. A person with mental illness should be able to have access to primary care at the mental health center and it should be bi-directional. A person must have access to mental health care through primary care. NCQA certification would ensure standards for primary care practices. No primary care practice should receive a contract for Medicaid clients unless they are integrated with behavioral health and the reverse applies as well. Health Homes need continuum of care components, including hospitals for inpatient care for both medical and behavioral health illnesses.

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?

Care Coordination is essential. Contracts with primary care physicians practice should fulfill the role of a care coordinator. A care coordinator is not necessary for every patient; instead, every patient should have a "care navigator." This person helps the patient overcome barriers to care.

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?

HFS should provide umbrella coverage and negotiate a pharmaceutical contract that would be available to all coordinated care entities. The formularies must include drugs that will impact quality of care and cost reductions. If physicians adopt best practices and have formalized treatment guidelines, they will be les autonomous in prescribing practices. They will have a financial vested interest in prescribing cost-effective treatments, complying with formularies, and following recommended treatment guidelines established by HFS. This also will mean the pharmaceutical companies will have less influence on the prescriber.

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

Incentives could be in the form of EMR systems. This, as we all know, will be a key component to coordinated care. If there were a matched dollar amount toward the roll out of an EMR, it would be positive for HFS, as well as the contracted agency/practices.

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

<u>Questions for comment</u>

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

Quality measures such as health outcomes, patient perceptions and the system of health care should be considered. The system of health care should be related to whether or not there is integration between primary care and behavioral health. Further down the line, there should be Integrations involving chronic disease specialists for asthma, diabetes etc.

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?

Standardized coordinated care measures should be applied across the board, regardless of population served.

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?

Under the Accountable Care Organization (ACO), which is becoming a widely accepted model, the organization must agree to become accountable for the quality, cost and overall care of the Medicaid/ Medicare fee for service beneficiaries assigned to it (not less than 5,000 individuals). This is a necessary requirement in care coordination if we intend to realize health care cost reductions and standardize the amount of client risk for all providers.

d) What kind of guidance is available concerning the number of measures that would make sense, especially since coordinated care covers a broad spectrum of care?

The ACO model is using quality measure of process, outcome and structure. They include functional status improvement, reduction in rates of avoidable readmissions to hospitals, rates of discharge to community, incidence of health care acquired infections, efficiency measure, measure of patient-directed care and measure of patient perception of care.

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

A shared savings approach such as used in the ACO Model is a consideration. The fee for service would be in place, but a shared savings payment would be an incentive. If health care costs were based on quality outcomes for patients, there would be less intensive services needed such as hospitalization. The provider is incentivized with shared savings from improving patient health. Payment must be established in a manner that costs less than non-integrated or non-coordinated care.

f) How can the Department most effectively work with other payors to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?

Do not re-invent the wheel. There are documented, proven, reliable measures already developed through National Council and others. The Department should support pilot projects for primary and behavioral health already established, such as the one in Rockford, Illinois, between Rosecrance/Janet Wattles (behavioral health care provider) and Crusader Community Health (FQHC) for a population of 350,000 and at least 8000 Medicaid recipients. Quality measures in this pilot will include global functioning scale using LOCUS, approved by DMH collaborative to determine level of care medically necessary for behavioral health care, Universal PHQ-9 screening tool for depression, reduction in rates of avoidable readmissions to hospitals, rates of discharge to the community, incidence of health care acquired infections, and measure of patient choice and patient perception.

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

Care coordination will be achieved when treatment needs and goals established for the patient are deliberately met on a consistent basis. Care Coordination will be achieved when the appropriate delivery and amount of health care is achieved, even when challenging. We will know care coordination is achieved when care is provided without boundaries. This entails the primary care/behavioral health care giver interfacing with the health care community and the continuum of care components, including hospitals for inpatient care for both medical and behavioral health illnesses.

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

Questions for Comment

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?

Critical patient-related information to facilitate effective coordination and medical decision making must be exchanged.

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

There should be financial incentives for EMR implementation. It is imperative to have EMR capabilities for Coordinated Care. Having referring clinicians and specialists who exchange information infrequently and in non-standardized ways may lead to adverse consequences for patient care.

c) If additional incentives were going to be added for being electronically enabled, that would inevitable mean less reimbursement somewhere else. How important are incentives above and beyond the ARRA incentives to include 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?)

Currently, most electronic billing results in prompt payment and this resulted in electronic submission increasing significantly. It is not always about additional dollar incentives, as it is about predictability and efficiencies.

d) On what time frame should we expect all practices to be electronically enabled? How would we operationalize the requirement? Is tying them to the official “meaningful use” requirements enough?

EMR roll outs should be accomplished on the same time table as the “meaningful use” requirements.

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

a) How much risk should be necessary to quality as risk-based?
b) Could "risk-based arrangement" 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?
c) If initially included, over what time frame should these arrangements is replaced with the acceptance of down-side risk?
d) What should be the relative size of potential payments conditioned on whether a provider is accepting full risk as compared to a shared saving model?
e) In the case of either a capitated or a shred-savings model, what should be the maximum amount of "bonus"? Stated differently, what is the minimum Medical Loss Ratio for a provider?
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?
g) How should risk adjustment be included in the model? Conversely, how should "stop loss" or "reinsurance" programs be incorporated?
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?

Capitation could be used. There must be a requirement for a certain number of Medicaid/Medicare recipients to be accepted. In an ACO Model there will be 5,000 Medicaid recipients for three years. Time frames are important for consistency and continuity of care. Spending limits must be projected, and this will be accomplished by looking at historical data. There has to be reasonable savings assumptions to provide the confidence that real overall savings will be able to be achieved. If the cost for treating the entire population with your contracted group of providers is expected to increase 5% next year, and if the provider is able to beat the projection by keeping their increase to 2%, the provider will get to keep some portion of the extra 3%. The providers would no longer work in silos because they will have to make sure there is no duplication of test. Providers will have to communicate with one another and treat the patient as a team. They have incentives to make sure they do all the right things to prevent readmissions because they know they are getting paid a capped fee based on the average cost of treatment. This is definitely shared risk, however; the Rockford coordinated care project will demonstrate the providers' expertise in treating chronic disease, both on the behavioral health side and the primary care side. This is not as much about financial risk as it is about the collaboration and integration between the plan and the system developed to deliver the care.

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

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?

Medicaid should lead the market. The model should be an integrated system that is capitated to control the cost and quality of care for a population of patients. This model will complement health homes as an essential component. The Department should contract primarily with proven models in the beginning.

b) What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements? How should the determination of "minimal financial base" be different for one and two-sided risk arrangements? Should Department of Insurance Certification be required? In the beginning, the provider would see a small modification to existing fee-for-service payments with providers receiving payment of withholds or bonuses if they perform well on measures of quality and efficiency. Providers need not deal with substantial financial risk. This would allow the payer to implement this method with existing data.

The financial base must be determined through financial audits. History of practice is significant and should be examined.

c) Should there be a minimum number of enrollees required in an entity for it to be financially stable and worth the administrative resources necessary to accommodate it and monitor it? Should that amount differ by types of client? Can it be different for entities taking one-sided as opposed to two sided risk?

The ACO model requires at least 5000 Medicaid/Medicare recipients and this seems to be a recommended minimum. Each coordinated care entity is accountable for cost of healthcare for beneficiaries. This number of enrollees will require an adequate number of primary care physicians to provide care. A larger coordinated entity such as this would be more cost effective to monitor and worth administrative resources.

6. What should be the requirements for client assignment?

Questions for Comment

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?

a-i) Client assignment could be assigned according to the Four Quadrant Model promoted by National Council for Community Behavioral healthcare. The Four

Quadrant Clinical Integration Model is an Evidence-Based model. This model has been adopted by the coordinated care project between Rosecrance/Janet Wattles and Crusader Community Health in Rockford, Illinois.

Quadrant I: The population with low to moderate risk/complexity for both behavioral and physical health issues.

Clinical Model

- Medical home/principal clinical site is Primary Care
- Embedded licensed behavioral health professional in Primary Care pod will provide brief assessment interventions, consultation to primary care physician.

Quadrant II: The population with high behavioral health risk/complexity and low to moderate physical health risk/complexity.

Clinical Model

- Bi-directional care with primary care having a medical exam room capacity at Community Mental Health Center.

Quadrant III: The population with low to moderate behavioral health risk/complexity and high physical health risk/complexity.

Clinical Model

- Medical home/principal clinical site is Primary Care.
- Embedded licensed behavioral health professional in Primary Care pod provides brief assessment and interventions, consultation to primary care, referrals to other levels of care and community resources
- Additional specialty care to have behavioral health professional embedded

√ HIV/AIDS clinic
√ High Risk OB, Continue Post Partum screening
√ Pain Management Program
√ Wellness component for chronic condition

Quadrant IV: The population with high risk and complexity in regard to both behavioral and physical health.

Clinical Model

Community Mental Health Center is principal Behavioral Health clinical site. Primary Care/FQHC is health home for health care needs with other specialists involved, as well. Use focused case consultations to coordinate care.

- Behavioral health to use Evidence-Based Practices (EBPs for Quadrant IV patients):
  - √ Recovery Model
  - √ Family support and education
  - √ (ACT) Assertive Community Treatment Teams
  - √ Integrated Dual Disorder Treatment (IDDT) SAMHSA evidenced based treatment
  - √ Medication algorithms
  - √ (WRAP) Mary Ellen Copeland's Wellness Recovery Action Plan
- Primary Care Physician is embedded in Community Mental Health Center serving mainly adults.
  - √ Initial history and physical for new patients
  - √ Preventive screening for ongoing patients
  - √ Medical clearance of inpatient psychiatric admissions
  - √ Coordination with outside primary care physician, if patient already has medical home, as well as specialty providers
  - √ Patient healthcare education and wellness support
- More complex medical component requires that primary care physician has ready access to Specialty Care Physicians.

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

Questions for Comment

a) How do we assume continuity of care as entities come and go or change contractual status?

Continuity of care must be one of the goals of coordinated care. The ACO model recommends a three year commitment from the coordinated care entity. The patients assigned to a specific care entity can request a referral to a physician outside the Coordinated care entity therefore it puts more pressure on the coordinated care entity physician to provide quality care while providing cost effective care. The patient must be satisfied or they could seek out another physician. Patient choice should drive the quality of care. Patients should have the ability to chose another provider if dissatisfied. This would incentivize primary care physician to satisfy his/her customers. Physicians control cost of health care for their participants when they collaborate and make sure there is no duplication and ensure quality care.

b) How can continuity of care be maintained for low income clients across Medicaid and other subsidized insurance program?

Any coordinated care group accepting contracts must include a percentage of low-income clients across Medicaid and other subsidized insurance programs for a certain time limit. The ACO model requires at least 5,000 patients with Medicaid/Medicare for minimum of three years. The three year time limit will not only ensure continuity

for the patients but it will impact quality of care in a positive direction.

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

Questions for Comment

a) How would your organization participate in coordinated care?

Crusader Community Health (FQHC), with four locations in Winnebago and Boone County, serves over 45,000 patients per year with primary care, dental and limited on-site specialty care. Rosecrance Health Network and Janet Wattles Center, an affiliate of Rosecrance, annually provide behavioral health services to more than 13,000 patients and consumers who need treatment for substance use and mental health disorders per year. Approximately 8,000 are Medicaid/Medicare recipients.

The two organizations have developed and are ready to pilot an integrated, comprehensive collaboration to meet the needs of common and unique patients of all ages of each organization.

Purpose of collaboration:

- Increase positive outcomes for patients
- Reduce overall cost of care
- Avoid duplication of services
- Reduce criminal justice costs, including incarceration and court expenses
- Reduce demand for emergency care or as much inpatient hospital care as possible
- Increase number of stable, health, productive community members

Elements of collaboration:

- Initially, one full-time licensed behavioral health professional from Rosecrance/Janet Wattles Center will be embedded at Crusader Community Health facility on West State Street with primary care Physicians. The intention is subsequently having one licensed full-time behavioral health professional at each Crusader Community Health location.
- This licensed behavioral health professional will be full-time and able to consult with patients and primary care providers on a real-time basis, providing screening, assessment, crisis intervention and crisis counseling using a solution-focused model.

- The services may be offered to patients pre-appointment, during the appointment or post-appointment, as indicated by screening tools, primary care provider hand-off or medical record review.

- Patient records will be maintained in the electronic medical records of each separate organization by each organization's providers and electronically shared with the other organization upon obtaining an appropriate written release from the patients.

- The licensed behavioral health professional will serve as liaison to Rosecrance/Janet Wattles psychiatrists for consultation and assessment. They will coordinate appropriate referrals to other community organizations when appropriate.

- Consistent with a bi-directional service model, patients with serious mental illness may be referred for care to Rosecrance/Janet Wattles Center. These patients may be referred back to Crusader Community Health for primary care due to high numbers of Quadrant IV. Consumers have a lifetime of poor health habits and increased use of SSRI's which have been noted to be related to increase weight gain, diabetes another problems. While the population retains a diagnosis of serious mental illness, many symptoms of the psychiatric disorder have been stabilized over time, but the physical health needs of the individual increase with age.

- The collaboration, with a licensed behavioral health specialist integrating into primary care, as well as the bi-directional service delivery with nurse practitioner providing health care for individuals with serious mental illness at Rosecrance/Janet Wattles will address a critical need in our community by providing better access to healthcare and more positive outcomes for people with mental health and substance use disorders.

Mary Ann Abate MS LSW
VP/COO Mental Health
Janet Wattles Center/Rosecrance Health Network
Fax 815 968 5314
Cell 815 985 0540
Office 815 720 5040