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THE COORDINATED CARE PROGRAM KEY POLICY ISSUES June 2011

The Medicaid reform law adopted by the Illinois General Assembly in 2011, P.A. 96-1501, mandates that 50 percent of all Illinois Medicaid recipients be in coordinated care by January 1, 2015. (Relevant language from this law is attached to this document.) While outlining a general sense of direction for the Medicaid program, the legislation leaves key operational issues to be determined by the Department of Healthcare and Family Services. This paper helps identify some of the issues and seeks public and stakeholder advice on how to implement coordinated care in Illinois.

Initially we are inviting stakeholders to provide written comment in response to the following specific policy questions. Subsequently, we will hold public hearings to discuss the responses, focusing particularly on those areas where there is no consensus.

Please note that "Medicaid" is used in this document to apply to all State comprehensive medical health programs, including the Children's Health Insurance Program and certain related state-funded programs, as enumerated in the legislation.

Please submit your comments electronically to dfs.webmaster@illinois.gov no later than close of business, July 1. All comments will be posted on the Coordinated Care tab on the HFS website. We will subsequently announce hearings during the summer.

Although the legislation requires at least 50% of all clients to be enrolled in coordination care by January 1, 2015, there are two important realities that will shape implementation of this policy: and are useful to set the context for the issues in this paper:

- About 45% of our current enrollees live in Chicago, another 14% live in Kane, DuPage, Lake and Will counties, and another 10% in a handful of downstate urban counties. The remaining 30% of our clients are scattered over 87 rural counties. While we believe everyone should have coordinated care, it will be difficult to offer the same delivery systems in the 87 rural counties that we offer in the more densely populated areas. Therefore, it will be practical to focus initially on the higher density areas – possibly enrolling materially more than 50% of the clients in these areas to meet the 50% statewide target.
- The Department will begin enrolling newly eligible Medicaid clients under the Affordable Care Act in the fall of 2013. This means we will have to establish coordinated delivery systems in place prior to the fall of 2013.

Below are the specific questions on which we are seeking comments. Comments do not need to address all questions, but as much as possible, all comments should respond to specific questions. Since many of the issues are interconnected, there may be multiple ways of arranging responses. Issues for comment are organized as follows:

- How comprehensive must coordinated care be?
- What should be appropriate measures for health care outcomes and evidence-based practices?
- To what extent should electronic information capabilities be required?
- What are the risk-based payment arrangements that should be included in care coordination?
- What structural characteristics should be required for new models of coordinated care?
- What should be the requirements for client assignment?
- How should consumer rights and continuity of care be protected?
- What is your organization’s preliminary anticipation of how it might participate in coordinated care?

1. *How comprehensive must coordinated care be?*

The legislation is clear that to meet the definition of coordinated care, an entity must provide or arrange for the “majority of care”, including a patient-centered medical home with a primary care physician, referrals from the primary care physician, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, and when appropriate, rehabilitation and long-term care services. The law also requires arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the use of electronic medical records, and the appropriate exchange of health information electronically.

This comprehensive definition does not contemplate coordinated care coverage for specific diseases,

such as management of asthma or diabetes. It does not preclude, however, organizations that offer comprehensive services or care management tailored to people with specific diseases or conditions working with other entities serving a broader population. In addition, medical homes will be required components of coordinated care, but by themselves will not be sufficient to meet the requirement for accepting responsibility over all services.

Coordinated care in Illinois is contemplated to include a wider range of potential arrangements than traditional, fully capitated managed care. Coordinated care entities could be organized by hospitals, physician groups, FQHCs or social service organizations. While the Department would like to test these new models, we need to determine the current level of interest and capacity to offer these comprehensive, risk-based services through the Medicaid Program.

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?
- 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?
- c) Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operationalized? 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?
- 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?
- 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?
- f) What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?

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

The law requires payment based on outcomes and use of evidence-based practice. How should this be operationalized? There is an emerging body of research and analysis on outcomes and evidence-based practice. Presumably the State will establish a set of measures and standards and create incentives relative to those measures. The difficulty will be balancing the number of measures that could possibly

go into defining high quality care with the need to keep the incentive packages administratively manageable. Whatever measures are used should be chosen from nationally accepted measures (e.g. HEDIS, CMS Quality Measures, etc.).

Questions for Comment

- a) What are the most important quality measures that should be considered?
- 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?
- 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?
- 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?
- e) What percentage of total payment should be specifically tied to quality measures?
- 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?
- g) How will we know when we have achieved care coordination, i.e. how should we measure success?

3. 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.

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

- 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?

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.

Questions for Comment

- a) How much risk should be necessary to qualify as risk-based?
- 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?
- c) If initially included, over what time frame should these arrangements be 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 savings model?
- 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?
- 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?

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

Assuming the Department enters into contracts with entities other than managed care entities, the Department must have criteria to determine if the entity has the capability to successfully coordinate care for Medicaid clients.

Questions for Comment

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

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

Care coordination entities must serve an identified population that is enrolled in Medicaid; they cannot exclude any member of the population for which they are responsible – or individually "cherry-pick" their own enrollees. The current Illinois Health Connect program (Medicaid's Primary Care Case Management program) requires that all Medicaid clients be enrolled with a specific primary care provider. Under the new policy, Medicaid clients may be required to enroll in a specific care coordination program, with enrollee protections to assure quality and access. Steps should be taken to maximize the proportion of clients who voluntary enroll (self-assign), but when clients do not choose, how should they be assigned?

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?

- 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?
- 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)?
- d) On what basis should assignment of clients who have not self-assigned be made in the first year?
- e) One approach would be to make auto-assignment to capacity in proportion to the self-assigning choices. Another approach would be to allow providers to bid on slots, with lower rates getting a larger proportion of the auto-assignees. What are the strengths and weaknesses of these approaches? Are there other approaches?
- f) Over time, the auto-assignment bases could change: one approach would be to make auto-assignment in relation to outcomes. Cost could also be a factor. How long a period should be allowed before switching to a more experienced-based formula?
- g) Whether for self or auto-assignment, should there be a client lock-in period? If so, for how long? What safety mechanism should exist for clients where stringent enforcement of the lock-in would be detrimental?
- h) If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?
- i) How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?

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

Over the last 20 years, the managed care model has matured significantly. It has moved from an emphasis on disapproving care to an emphasis on actually coordinating care. This emphasis has been reinforced by the more rigorous review of managed care entities (such as NCQA assurances) and, at the current time, there is good reason to believe that the degree of quality assurance and oversight in the managed care market is greater than what exists in the fee-for-service market, in which every patient is required to fend for herself with little oversight or assistance. As part of maintaining, and building on, these improvements, however, it is appropriate to assure that clients have reasonably defined ways of expressing their satisfaction with the care they are receiving and have issues addressed, whether they are enrolled in traditional managed care entities or some alternative coordinated care model.

In addition, after January 1, 2014, the Health Benefits Exchange will become operational under the Affordable Care Act. Newly eligible Medicaid clients in Illinois would likely be offered coordinated care; other clients over the 133% Federal Poverty Level threshold would be shopping for private health insurance, with tax subsidies. The Department is committed to making sure that clients' can continue to use the same providers, even if their source of funding is changed due to shifting income.

Questions for Comment

- a) How do we assume continuity of care as entities come and go or change contractual status? (This issue could be particularly acute if HFS "leads" the market by allowing contracting with entities for whom Medicaid is their only coordinated care contact.)
- 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)?
- c) Should plans be required to offer plans in both Medicaid and the Exchange, with essentially transparent movement from one to the other if client income or circumstances change?
- d) What rights, if any, should the client have to continue a medical home relationship in changing circumstances?
- e) What mechanisms should be required to obtain client information on an ongoing basis about plan quality? What appeal rights might be necessary?

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

While this paper makes it clear that there are numerous policy issues that are open for discussion, it is our hope that the range of issues raised also makes it clear that the State is committed to testing new models in addition to traditional managed care. Recognizing that any intentions at this point are preliminary, it would be useful to get some sense of how various providers and provider groups are thinking they might participate in coordinated care.

Questions for comment:

- a) How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care Networks or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't sure how your organization would participate, what would be some of the factors impacting your choice?

- b) Do you have some model in mind that you think would work to meet the terms of the law and also work well for you and the patients you serve? If so, please share it.
 - c) Is your organization considering developing a Medicare ACO? Do you see opportunities for entities like ACOs in the private market? How do you see yourself involved in either Medicare or other forms of ACOs?
 - d) If your organization is considering participating in Medicaid coordinated care in some way beyond contracting with coordinated care entities, do you think you will be ready to do so by mid-2013? If not, when?
 - e) For how many Medicaid clients could you anticipate taking coordinated care responsibility? Is there a particular group of clients for whom you believe your organization is particularly suited or for whom it has developed particular expertise?
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There are undoubtedly areas for comment that we have failed to include or specific questions that we omitted within the general areas we selected. Please feel free to offer comments beyond the specific questions posed, but try to make your comments as specific as possible. The purpose of this paper is to receive your input as HFS moves from the broad policy outlines provided by the law to policies necessary to implement the law in a fair and beneficial manner.

Once again, please submit comments to hfs.webmaster@illinois.gov **by close of business, Friday, July 1**. If you have specific questions, please pose them to the same address and we will get back to you. You should watch the Coordinated Care tab in the HFS website as we will post updates and, as relevant, clarifications and answers to broadly relevant questions as we have them prior to July 1.

Thank you very much for your input. We want to make this process as open and participative as possible.

ATTACHMENT: Language in P.A. 96-1501 Mandating Coordinated Care

<p>(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.</p>
<p>(b) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the use of primary care delivered through comprehensive medical homes, the use of electronic medical records, and the appropriate exchange of health information electronically made either on a capitated basis in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements.</p>
<p>(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the effective date of this amendatory Act.</p>