

Advancing the human and civil rights of people with disabilities

SELF-ADVOCACY ASSISTANCE ★ LEGAL SERVICES ★ DISABILITY RIGHTS EDUCATION ★ PUBLIC POLICY ADVOCACY ★ ABUSE INVESTIGATIONS

June 30, 2011

Ms. Julie Hamos
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, Illinois 62763-0002
E-mail: Hfs.webmaster@illinois.gov

Via E-mail

Re: Comments on the Coordinated Care Program, Key Policy Issues

Dear Director Hamos:

We would like to thank the Department of Healthcare and Family Services (HFS) for issuing the discussion paper entitled, "The Coordinated Care Program, Key Policy Issues" and for seeking stakeholder input on the issues associated with moving Medicaid recipients to a coordinated care system. As the protection and advocacy system for people with disabilities in Illinois, Equip for Equality respectfully submits the following comments regarding coordinated care generally and in response to the specific questions in the discussion paper.

Over the past year, we have been involved in discussions concerning the Integrated Care Pilot Program enrolling 40,000 Medicaid recipients in Suburban Cook and the Collar Counties in managed care. We have raised concerns regarding accessibility, availability, and quality of care in this program and have consulted with people with disabilities and other advocates regarding their concerns. These concerns largely extend to any system of coordinated care, but are particularly relevant as HFS considers whether or not to enroll more Medicaid recipients in "traditional" full-risk capitated managed care programs.

1. How comprehensive must coordinated care be?

We believe that HFS should explore much more than traditional managed care options as it seeks to meet the 50% threshold mandated by the Medicaid Reform Law (P.A. 96-1501). We acknowledge that truly coordinated and integrated care systems may help to improve the health status and well-being of people with disabilities. Studies have shown and other states have had much success when using models involving medical homes and other outreach to insure that each individual is receiving care from systems which communicate with each other and the individual. We have seen the problems that a segregated and disjointed system can cause. However, coordinating care does not have to mean using a traditional insurance company with full-risk capitated payments. It can be as broad as assembling a team of physicians, specialists,

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other health care providers, social service agencies, and others who work together to achieve the best possible health outcomes for an individual. In fact, this non-traditional care coordination has been shown to achieve better outcomes and satisfaction than traditional models. We urge HFS to explore and invest in these types of coordinated care.

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

We agree with HFS that whatever measures are used should be chosen from nationally accepted measures. Many of the nationally accepted measures include measures which incorporate principles that are important to people with disabilities, such as the use of person centered planning, consumer control, and allowing individuals to live in the most integrated setting appropriate to meet their needs. HFS should use these already established and proven measures to assess health care outcomes.

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

Quality measures that address consumer satisfaction should be the primary consideration in evaluating health care outcomes. All too often, health care systems are designed without real consumer input and without regard for what the individual desires. Quality measures that address the level of satisfaction of an individual provide meaningful data on whether the health care system is meeting the individual's needs and desires.

Further, we urge HFS to adopt at least some quality measures that include rebalancing of institutional care with care delivered in the community, as well as measures that emphasize serving individuals in the most integrated setting appropriate to their needs. For many individuals, community living is both their choice and the setting that provides the best health outcomes. When adopting any models of coordinated care, HFS must be ever cognizant of this principle. Adopting quality measures that prioritize rebalancing and community based services will help to reinforce this principle.

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

Although we are not comfortable offering an exact percentage of total payment, we think that the percentage should be significant, and certainly higher than 5%. HFS has repeatedly asserted that it would like to change the Medicaid system so that only providers who use evidence-based practices and provide quality outcomes receive payments. The move toward coordinated care provides an ideal opportunity for HFS to do just that: incentivize practices and treatments that work and satisfy consumers and stop paying providers who are not meeting that standard.

HFS should also explore providing payments only to health care providers who meet a minimum number of quality measures. Given that there may be a fairly large number of

quality measures that measure a variety of different outcomes, it may be possible for a provider to meet a small number of quality measures consistently, while ignoring others, such as consumer satisfaction. To avoid such an outcome, we urge HFS to establish a minimum level of quality a provider must reach based not only on the number of required measures, but the type (i.e. consumer satisfaction).

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

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?

Having a minimum Medical Loss Ratio that is equal to the current medical loss ratio in the fee-for-service system will ensure that individuals are not losing access to or being denied necessary treatments because providers are seeking to maximize profits by denying care. Although far from perfect, the fee-for-service system does provide a good lesson in minimizing the amount of administrative costs and profit incentives, which may get in the way of providing quality medical care. Given that the ultimate goal of the Medicaid program is to provide high quality patient care in an efficient and effective way, there is no justification for allowing providers to increase their profit while providing less care to individuals under a new coordinated care program.

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

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?

Coordinated care should have as its ultimate goal providing Medicaid recipients with improved health outcomes and better care. Therefore, it seems obvious that the network of available providers and the access to primary care and specialists should at the very least be equal to the current network of providers in the fee-for-service system. We often hear from people with disabilities that they are having difficulty finding a provider who is willing to provide them with care and who understands their needs. It is critical that the coordinated care program developed by HFS not make this task any more difficult.

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

HFS' past experience in enrolling Medicaid recipients into new programs should provide it with valuable lessons and experience in reaching and educating future enrollees. The shift to any form of coordinated care will be a significant change for most Medicaid recipients. Therefore, HFS must continue to be cognizant of the varying levels of education and communication needs

of Medicaid recipients and tailor any information and communications regarding the new coordinated care program to meet the needs of these individuals. Any effort to enroll Medicaid recipients in coordinated care must be accompanied by a strong commitment by HFS to educate individuals regarding these changes and seek to partner with advocates and other stakeholders to reach target populations.

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?

While we are cognizant of the economic interests that make a lock-in period desirable, it is important that people with disabilities be given the flexibility to choose providers and health care delivery systems that meet their needs. Therefore, we suggest that lock-in periods be avoided entirely. If any lock-in period is used, we recommend that it be as short as possible and also be preceded by education regarding the consequences and details of the lock-in period. We would also suggest that any lock-in period be accompanied by an appeal process whereby an individual is given the opportunity to demonstrate the need for a change. Similarly, in the event that auto-assignment occurs, it should be preceded by a stringent effort to contact the individual and make him aware of the consequences of auto-assignment.

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

It appears HFS is primarily seeking comments on the continuity of care and potential issues that may arise from the health benefits exchange. But consumer satisfaction and the preservation of consumer rights are also critical and must be a priority in designing any coordinated care program. First, HFS should seek to ensure that Medicaid recipients have access to the care that they need in the settings that they choose. Second, HFS should seek to ensure that consumers know and understand their rights when they believe they have not been provided the care and/or service to which they are entitled. Because appeal processes are often utilized when transitioning from one system of care to another, consumer rights and continuity of care must not be separated. HFS should ensure that individuals are fully informed of their rights when they are transitioning into a coordinated care model and that there is a robust feedback and appeal process in place for any issues encountered.

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

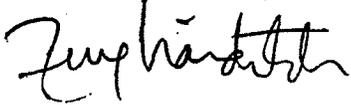
HFS should use a variety of mechanisms to gather information from clients regarding plan quality. As stated above, ensuring consumer satisfaction should be one of HFS' main goals when designing the coordinated care program. HFS should be mindful of the fact that certain individuals, such as those living in institutions, may have difficulty

communicating in traditional ways. HFS should be prepared to conduct special outreach to these individuals in order to ensure that coordinated care is meeting their needs.

Thank you again for the opportunity to provide input to HFS as it seeks to design coordinated care programs which can enhance health outcomes for Medicaid recipients. We look forward to working with HFS in the coming months on this issue.

If you should have any questions or need further input, please contact me or Melissa Picciola at (312) 341-0022, extension 7328.

Sincerely,

A handwritten signature in black ink, appearing to read "Zena Naiditch". The signature is fluid and cursive, with a large initial "Z" and a long, sweeping tail.

Zena Naiditch
President & CEO