

**The Coordinated Care Program
Key Policy Issues
Heartland Health Outreach Response**

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?

Literature shows that people with chronic conditions on average see a minimum of three to five providers per year. In the U.S., 9 million people with both Medicaid and Medicare (dual eligibles, who are poor, often elderly, and often disabled) are responsible for 40 percent of Medicaid spending. Their care is complex and often disjointed, focused more on intervention for acute concerns and less on continuous monitoring, prevention, and health management.

Achieving the three aims of ACOs—better healthcare, better health, and reduced costs—requires coordinating care across a spectrum of providers, especially for individuals with chronic health conditions. Because multiple conditions—including mental health and substance use disorders—can impact one another, it is essential that care be coordinated. Further, care coordination requires relationships and communication mechanisms that ensure that specialists, primary care providers, and community health workers coordinate care and promote health.

It is essential that the system foster creative approaches and responses to emerging epidemiological or other public health concerns as it monitors provider achievement. To this end, we recommend that HFS approach its relationship with providers and consumers as partners (just as it has in asking for provider responses to this questionnaire). The division, along with its provider partners, should develop and maintain mechanisms to share information, explore and implement best and promising practices, evaluate system as well as provider performance, and identify opportunities for collaboration and creative problem-solving. With HFS at the policy helm, the business of CCO implementation should be left to the expertise of providers, with input from consumers.

In partnership with providers, HFS should establish broad standards for care that include a comprehensive focus. However, HFS and its provider partners should remain open to a variety of service configurations. For instance, in order to address social determinants of health, coordinated care entities may be developed to reflect and incorporate the unique cultural attributes of a particular population and community. Some coordinated care organizations may incorporate strategies to address the socioeconomic circumstances that impact the health of their members. Others may center on the unique needs that accompany one or more chronic health conditions. In each instance, while standards for care are comprehensive and providers are held accountable for meeting health outcomes, the means for attaining those standards and achieving those outcomes are left up to the provider.

- 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?

In recognition of its providers as partners, HFS should involve them in the development of system-level goals (starter measures should include emergency department visits, hospitalizations, costs per person, functional status, evidence of care coordination, and consumer experience). From these goals, the elements that contribute to comprehensive care should be outlined. There will also need to be recognition that such a shift in care organization will require up-front investment as well as systemic reorganization. As a result, a developmental approach should be taken and recognition given that some of the elements may need to change over time. HFS should encourage and support efforts to implement evidence-based and promising practices.

- 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?

Requiring a National Committee for Quality Assurance (NCQA) certification, planned JCAHO Medical Home standards or National Quality Forum partnership would undoubtedly be cost prohibitive and may prevent organizations that are not large hospital-based healthcare systems from participating. This, in turn, may serve to quash targeted, creative, and flexible responses to unique regional, condition-specific, or population-related needs.

Rather, HFS should require that every hub be able to meet the needs of vulnerable populations, such as individuals experiencing chronic homelessness and those with serious mental health concerns and medical conditions, by meeting certain performance thresholds. While there should be no wrong door through which a consumer enters the system, we also recognize that a dynamic system will encourage a variety of service configurations and promote dialogue among partners to ensure providers and consumers are aware of all the healthcare options the system offers.

Essential considerations for every practice should include the ability to provide or link to comprehensive care; the capacity to measure the effectiveness of the care it delivers; the ability to communicate clinical information within its own network as well as to transmit it to other providers who come into contact with the consumer; and its fiscal capacity to oversee a coordinated care organization. As HFS sets these standards, it must also understand that the system's health is closely tied to the fiscal health of each of its provider partners. This core orientation should inform decisions related to how risk is shared. As partners in system-level planning, providers would have a role in negotiating the risk relationship with HFS and, as a result, would be more likely to engage in creative, flexible approaches to problem-solving.

- 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?

HFS's requirements should be achievement oriented, not process oriented. The goal is to provide the right care, at the right time, in the right setting. It is important—especially so early in this process—that HFS stay focused on the health-related outcomes it intends to achieve with reform, not the methods it expects providers to use to meet these goals. Though the use of integrators, community health teams, and care coordinators is likely to be a best practice, it should not be required for each enrollee. Rather, HFS should make available evidence-based practice guidelines and encourage inter-organizational dialogue on best practices throughout the state.

As a corollary to the above, HFS should not limit who can deliver care. For instance, social workers, counselors, case managers, peer-providers, health coaches or navigators, and other mental health professionals have proven to be as effective as nurses in promoting integrated care for vulnerable consumers. Thus, HFS should encourage and support the inclusion of these disciplines on care teams, which will both support consumers and forward the development of truly coordinated 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 in areas where it will lower cost, such as arranging pharmaceutical contracts and medical supplies. With providers as partners, the entire system can benefit from savings. Overall savings should be reinvested in improved and expanded healthcare—not go to the state's bottom line.

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

To ensure that the unique needs of vulnerable populations are addressed within Illinois's publicly funded healthcare system, higher reimbursement rates or risk-based premium adjustments should be available to those networks serving members of this population. Cost data based on diagnosis and service utilization can be the basis for such adjustments.

Further, opportunities to become, or partner with, a coordinated care organization should not be restricted to large hospital-based healthcare systems. By requiring NCQA, JCAHO or NQF certifications, or other cost prohibitive accreditations, Federally Qualified Health Centers (FQHCs) and other community-based organizations could be excluded from participating as either a coordinated care organization or even as a provider partner.

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?

Outcomes for vulnerable populations (the poor, the elderly, the homeless, those with chronic co-occurring conditions) must be measured by different standards than those applied to the general population. This is especially true for those who have gone many years without access to care: individuals who are newly engaged through the expansion of Medicaid will likely present with long-term, untreated illnesses that will not respond quickly to treatment. Further, these individuals may not trust providers, be suspicious of health settings, services, and systems, and find it difficult to communicate with or understand providers.

Evidence suggests that engagement in services is directly linked to improvements in functioning for individuals who are traditionally underserved. Potential outcomes should include process-oriented achievements like treatment acceptance and retention, as well as obtaining and maintaining stable housing, income supports, or other resources that promote positive health outcomes. Starter measures should include emergency department visits, hospitalizations, costs per person, functional status, evidence of care coordination, and consumer experience.

- 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?

As HFS moves to create innovative healthcare solutions, it will benefit from partnerships with providers who specialize in serving vulnerable people in the development of measures related to the needs of members of this population. Many providers who serve these individuals already rely on various population-specific outcome measures that should be considered. There should also be different measures for vulnerable children versus children with fewer social, familial, or health-related concerns.

- 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?

Just as outcomes for vulnerable populations must be adjusted, so must the financial risk be adjusted (as is currently done with regards to age or other considerations). Individuals who have experienced long-term homelessness, who are precariously housed, or who are at risk of homelessness; refugees; those with mental illness, substance use disorders, and chronic medical conditions; and others who have historically been alienated by the traditional health care system will require more services and be more expensive than individuals who have had better, more consistent access to care. Reimbursement rates and risk-based payment models must be adjusted accordingly, not only to provide incentives to serve vulnerable people but also to ensure that the providers serving these individuals have the fiscal resources to adequately meet their diverse needs.

A dynamic public healthcare system will develop mechanisms to ensure that provider partners regularly engage with HFS in discussions about the fiscal ramifications of addressing systemic shortcomings or emerging problem areas. From these conversations, collaborative solutions based on models that provide incentives for flexibility, creativity, and risk-taking can emerge.

- 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?

Because evidence suggests that participation in treatment is highly correlated with improvements in functioning, we recommend measurement of both process and effectiveness. A participant's engagement in services is essential to those services having a positive impact on his or her life. At HHO, we assess engagement in, as well as experience with, services to measure the effectiveness of our treatment processes. We also gauge the effectiveness of our services through measurement of days spent in the community without use of institution-based care, reduction of symptoms, improvement in self-care including disease management, and willingness to engage in behavior-based change.

- e) What percentage of total payment should be specifically tied to quality measures?
In order to serve vulnerable populations effectively, quality measures must be adjusted accordingly. Payment options that will be tied to these adjusted quality measures must include up-side risk arrangements, such as pay-for-performance and one-sided shared savings model, in order to allow providers to take the “risk” to serve this group of individuals.

As the system evolves—with input from HFS, provider partners, and consumers—the percentage of total payment that is tied to quality measures will likely evolve as well. Initially, the system will be struggling to meet increased demand and address longstanding health concerns of historically underserved populations. Therefore, initial efforts will center on engagement in treatment, assessment/diagnosis, stabilization of disease, and healthcare system transformation. Quality measures will need to address these initial efforts. Later work will center on health management, chronic disease management, and prevention. As the system evolves, so, too, will its goals and the quality measures related to those goals.

- 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?

HFS needs to create relationships with the other systems that most affect vulnerable consumers and have a role in their healthcare—specifically, DCFS, the Department of Corrections, Early Intervention, DMH, DASA, DRS, IDPH. They need to come to the table, identify the barriers and gaps in the continuum of treatment, and develop systems integration initiatives that will remedy the astonishing disjunction among these systems. Out of this will come consistency of care across systems, increased access and decreased discontinuity, and better health and societal outcomes—and an increased likelihood of actually meeting the goals of Healthy People 2020.

Further, housing, employment, income supports, and education all contribute to one’s ability to maintain wellness. HFS should work with its provider partners to effectively relate the value of healthcare to the optimal functioning of other systems. Providers have had to make this argument in order to secure support and funding for their initiatives and, as a result, have a good track record of quantifying and describing the ripple effect of their services.

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

We see care coordination as an ongoing, system-level conversation that will always face the challenge of responding to emerging needs and shifting social, economic, and epidemiological conditions. As a result, we recommend a system in which the department establishes formal mechanisms to ensure a rich and forthright discussion with its provider partners and consumers. We envision this discussion as person-centered and data-driven while encouraging innovation; it must be flexible enough to re-allocate resources as needed. From this foundation, a coordinated system of care will evolve that:

- Ensures those most in need are engaged in services;
- Identifies high-risk consumers and develops mitigation plans;

- Links people to the services and supports that help them to achieve stability within the community;
- Shifts service location from acute and long-term care settings to community providers;
- Addresses barriers to care and increases access in creative and flexible ways;
- Uses an electronic health record to ensure that providers have access to consumer data;
- Learns of and incorporates best practices;
- Encourages and supports inter-organizational, multidisciplinary communication about care;
- Continually evaluates system-level success and challenges, while engaging in collaborative goal-setting to address problem areas or emerging trends;
- Remains cost conscious and prioritizes savings for increased access or reinvestment, while providing quality care;
- Does not put limits on necessary services;
- Continually monitors consumer satisfaction and incorporates consumer feedback into its planning process;
- Holds provider partners accountable for achieving system-derived outcomes;
- Engages other systems in efforts to address the social determinants of health to improve the health of Illinoisans; and
- Gives consumers a meaningful voice in the conversation at the system level.

At the provider-partner level, the department will know that coordinated care is underway and effective when providers are effectively:

- Engaging consumers in services;
- Motivating consumers to participate in preventive services and behaviors;
- Supporting those with chronic conditions to self-manage their illnesses;
- Helping vulnerable populations maintain community stability;
- Providing parents the supports necessary to help their children achieve developmental benchmarks;
- Reviewing their own outcomes, as well as those set forth by the department, for purposes of quality improvement;
- Learning about and incorporating emerging best practices;
- Sharing information about and coordinating the treatment of consumers between organizations;
- Documenting and reporting on service delivery via health information technology that meets the emerging federal standards for meaningful use; and
- Develops mechanisms for including consumers in an advisory capacity.

At the consumer level, the department will know that coordinated care is underway and effective when participants are:

- Choosing primary care providers over emergency departments for routine care;
- Consistently engaging in services at regular intervals;
- Managing chronic health conditions without the need for high-intensity, acute care; and
- Reporting satisfaction with their providers;

- Demonstrating improved health outcomes; and
- Included in the development of coordinated care strategies.

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?

To efficiently and effectively coordinate care in a comprehensive manner, we think that an electronic health record system is essential, both for within- and across-system communication. HHO is a founding partner of the Alliance of Chicago Community Health Services, a collaborative formed approximately ten years ago to develop and integrate an inter-organizational electronic health record (EHR). The experience this collaborative has had working across organizations and disciplines can inform the department's efforts to develop a statewide system of health information collection, monitoring, and sharing. The department and its provider partners will need access to real time information for purposes of care coordination and utilization management. It will be essential that all provider partners incorporate an EHR that has the capacity to share patient information essential for coordinated care as well as to gather the outcome data required by the department. Ideally, the EHR can be used as a powerful tool for system analysis.

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

While it is best that HFS allow each individual provider to develop its own business practices, a set of standards for EHRs will undoubtedly be necessary. As ARRA funds are aimed at encouraging and supporting providers to purchase such systems, these funds were not intended to address state-level, systemic information-sharing. Thus, any standards promulgated by HFS that are beyond the scope of independent EHRs will require adjustments in software (and, perhaps some hardware upgrades) that are beyond the scope, and intent, of the ARRA funds. These essential capital costs will be initial infrastructure expenses that most community-based organizations will not have the resources to commit. In order to avoid establishing a barrier for flexible, community-based organizations to contribute their expertise to coordinated care networks, HFS will have to offer financial support for EHR expenses. ARRA-derived CMS payments do not require documentation of costs. Therefore there is no incentive to adopt more costly/robust systems. This presents an opportunity here is to incentivize or recognize such deeper investment if payments are cost-based.

- 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?)

Because these are business decisions that should be left up to each provider, we recommend that HFS provide a range of options, as described above, from which providers

could select. For example, a provider with limited capacity to pay for EHR implementation may make the business decision to elect upfront incentives to develop this infrastructure while another provider may choose to invest its own resources in EHR and, therefore, choose the down-stream option of outcome incentives. This will allow the department the opportunity to experiment with outcome incentives early on to learn more about implementing up-side risk arrangements.

- 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?

As with all aspects of the system's conversion to a model of coordinated care, EHR implementation will have to be phased in. In partnership with providers, HFS can establish realistic implementation targets. Further, as organizations assume risk, they will naturally find value in EHRs that provide the real-time, reliable data essential to monitor and tweak organizational performance. In this respect, the bottom line provides incentive for efficient data management. We have found that meaningful use requirements have set a high bar in that most current EHRs must pursue systems upgrades to meet these standards. As a result, we think that, at least initially, meaningful use requirements are sufficient.

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

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

A true partnership between HFS and providers will come to rest on how risk is negotiated. While it is essential that providers assume risk in order to improve system performance, it is also imperative that the system not allow fiscal risk to become a disincentive for clinical risk. That is, while we agree that an efficient health care system holds providers accountable for effectiveness, we also know that creative solutions to intractable problems require organizational behavior that does not center on the bottom line. Further, we are aware that many of the creative solutions to the system's current dilemmas lie in the hands of small, community-based organizations, including FQHCs which may not have developed adequate mechanisms to manage a significant degree of risk. It is important to note that these organizations have been disproportionately affected by current economic conditions (fewer dollars in the face of greater need) and are likely to be struggling.

While we recommend that risk-based contracting be incorporated from the beginning, we suggest that the percentage of risk start out low, be continually evaluated, and notched up in collaboration with provider partners over time. Initially, HFS may need to focus its allocation of risk on up-side incentives to engage provider partners in innovative solutions for high-need individuals. Over time, we believe that the department will be able to incorporate higher degrees of down-side risk to organizations that will have, by then, developed competence in such solutions and with such populations.

- 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?

We recommend models that incorporate both up-side risk to reward exemplary results in service to vulnerable populations. These results may be improved health, or they may be decreased costs. Down-side risk would punish those who underserve consumers: this

means they don't see a set number of individuals every year, or they don't provide an adequate range of baseline services.

- c) If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?

We look forward to a partnership with HFS whereby this decision is reached in collaboration with providers. We acknowledge that this requires providers to be willing to accept down-side risk and are, ourselves, so willing. We also know, however, that down-side risk poses a threat to a healthy healthcare system: it can't be so draconian that it causes providers to become protective of their bottom lines in a way that actually limits access to care, or, even worse, puts the provider out of business.

- 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?

These payment scenarios should not be looked at as one being better than the other as this question suggests. Rather, the conditions that support a full risk payment structure should be quite different than those that require a shared savings model. For instance, should HFS recognize an unaddressed need within its system, a shared savings approach would encourage a provider-partner to explore a creative solution to that need. Once that need is adequately addressed, it is possible that the provider could assume full risk or, at least, a higher degree of risk.

- 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?

Currently, the law requires that between 80 and 85 percent of an insurer's premium be spent on services. We think that this allocation can serve as a precedent for such a determination. It is imperative that HFS consider how surplus dollars are reinvested into the system to increase access or improve infrastructure.

- 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?

This is a business decision that should be left up to each coordinated care organization. Each CCO should be allowed to determine its own response to how individual contracts are negotiated within its network.

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

Innovation and partnership are key to ensuring a dynamic and flexible system. Risk adjustment models that accommodate consumer characteristics based on cost data are available.

- 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?

No provider can turn away anyone, regardless of their presenting problem or array of problems.

However, providers who seek out those who are the hardest and most expensive to treat should be rewarded. HFS can create formulas based on the incidence rate in the populations to be served by CCOs of particular diseases and disorders such as diabetes, heart disease, schizophrenia, and substance use disorders.

A 1-800 hotline should be available for complaints related to care provision. Any time a consumer disenrolls, that consumer should be contacted for follow-up and reason for departure.

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?

Illinois's healthcare system must be as diverse as its people. To adequately address the needs of Illinois residents, HFS should develop a system of coordinated care that invites and encourages the participation of innovative community-based organizations. Clearly, smaller organizations engaging higher percentages of vulnerable individuals will need reimbursement options that recognize the inherent financial risk of their endeavor. However, it is also clear that many of these smaller entities are already adept at effectively coordinating care for highly vulnerable individuals. The knowledge base that these organizations have to offer the system is of enormous value. Because many of these organizations concentrate their efforts on the needs of very low-income Illinoisans, Medicaid may be their primary payer.

- 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?

The CCO must have a capital base sufficient to cover losses, or else it must have reinsurance.

- 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?

Yes, there probably will need to be a minimum size expectation—but it will need to vary from one part of the state to another, based on population density. And there would also be the expectation that it might take a couple of years for a CCO to enroll its target number of participants. Other states' experience will be valuable in informing such a policy. Outcomes and cost per person should, however, ultimately drive HFS policy in this regard.

- 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?

The definition of coordinated care should take into account a set of predetermined, baseline array of services designed to meet the needs of an individual over a lifespan. HFS, in collaboration with providers, should create guidelines for quality care. However, how providers arrange for that care should be left up to the provider. Whatever condition needs

treatment, the CCO has to either provide the treatment or provide a referral and underwrite the expense.

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

We believe that special arrangements to serve vulnerable populations will need to be made, including models that provide up-side risk incentives such as pay-for-performance and one-sided shared savings plans; reimbursement rates that are appropriate to the population; and risk-adjusted outcome measurements.

We encourage the state to apply for the federally-funded health home option.

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? HFS should require that every provider partner be able to meet the needs of vulnerable populations such as individuals experiencing chronic homelessness and those with serious mental health concerns and medical conditions. While there should be no wrong door through which a consumer enters the system, we also recognize that a dynamic system will encourage a variety of service configurations and work from the center to promote dialogue among partners to ensure providers and consumers are aware of all the healthcare options the system offers.

- 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?

Geographic scope is less important than the comprehensiveness of the services offered. There would have to be significant demand for service in the designated area, specifically if the CCO's network only encompasses a particular neighborhood. Providers that maintain a practice that centers on addressing the needs of vulnerable people will likely cross geographic boundaries.

- 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)?

Coordinated care organizations should not be able to limit eligibility to improve their bottom line but should be allowed to specialize based on competency to meet the unique needs of historically underserved populations. In partnership with HFS, provider partners should be involved in efforts to strategically balance Illinois's publicly funded healthcare system. For instance, should it become evident that a particular population or region lacks adequate access to care, HFS should partner with providers to develop innovative solutions to address that need. Initially, HFS may have to provide incentives, like up-side risk arrangements, to encourage such innovation and support infrastructure development.

Once implemented, a more balanced risk profile should suffice to keep the new practice operational.

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

A solid approach would be for HFS to partner with providers to develop a matrix that tracks providers' scopes, including geographic location, cultural competencies, population-specific specialization, and demonstrated performance. Based on an analysis of consumer self-assignment as well as what is known of the consumer's need, consumers should be assigned to CCOs that either match their geographic location or address population and health-specific needs. The failure of consumers to self-select should be taken seriously as it is an indication that these individuals are not fully engaged in a dialogue about the value of health services. Because engagement in services is a key feature of effective care coordination, helping potential consumers resolve their ambivalence about entering care is, itself, a healthcare intervention. As a result, we believe that HFS's investment in enrollment specialists may play an important role in getting coordinated care off to a strong start.

When it comes to self-assignment: Keeping in mind that engagement in services is essential to maintaining control of costs, those who are known to utilize a high degree of services prior to enrollment should be targeted by enrollment specialists who will help them make the best decision. Of course, as the Affordable Care Act makes Medicaid accessible to a greater number of individuals, it can be expected that many of these people will not be familiar with the healthcare system as they have historically been underserved. Ideally, they, too, would have access to enrollment specialists who would be able to assist them in decision-making.

- 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?

In order to honor consumer choice and facilitate the best match between an individual and a CCO, self-assignment is far superior to auto-assignment. It seems far more likely that a consumer who selects a provider on his or her own will engage in coordinated care than one who is auto-assigned. Allowing providers to bid on slots with those with lower rates getting a larger proportion of the auto-assignees will result in those least likely to engage in services being matched to the providers who have the least financial incentive to engage them.

- 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 experience-based formula?

We look forward to a partnership with HFS whereby this decision is reached in collaboration with providers. While it is unclear how long a period should be allowed before switching to a more experience-based formula, it should be made clear to coordinated care entities from the start that this may become an element of the system. As providers are called upon to

partner with HFS in oversight of the healthcare system, they will need to be willing to acknowledge the need for such conditions.

- 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?

In order to adequately coordinate care and manage risk, there will have to be some sort of lock-in period (the typical lock-in period is one year). However, we maintain that, when it comes to their own lives, consumers are the ultimate experts. Therefore, they must have an avenue to adequately address their concerns about their coordinated care provider that includes the right to select an alternate provider during a predetermined annual open enrollment period. HFS should work with consumers and providers to develop a mechanism that first addresses their concerns within the structure of their coordinated care entity but, if those concerns remain unresolved, eventually allows them to select an alternate provider.

- h) If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?

By making the case to consumers that care coordination will be of benefit to them.

- i) How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?

These systems should not differ. Future healthcare organizations must be able to work with multiple payers and braid funding streams. The principles of care remain the same.

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

- 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.)

A robust EHR within each provider organization coupled with an ongoing collaborative dialogue at the community level will help ensure continuity of care should one provider leave the system thereby necessitating another to step in. For instance, if HFS continues to address system-level concerns with a body of providers, the formal and informal structures necessary to address a potential disruption in services will already be in place. In fact, it is possible that such a collaborative structure could itself function as the coordinating body for such transfers of care.

- 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)?

Meaningful use standards for EHRs as well as continuity with the ACA's Basic Health Plan provision can work together to ensure that individuals who transfer between market rate health insurance and Medicaid plans are adequately served. The more similar to one's

former healthcare plan (assuming, of course, that the individual was appropriately engaged by that plan) his or her Medicaid coverage is, the more likely he or she will be to continue to participate in essential health services. Engagement is key. Every time an individual drops out of coverage, the goals of coordinated care are harder to meet and the financial benefits of such care are harder to achieve. When the system works to make such a transfer as seamless as possible, the system is more likely to ensure that the individual continues to engage in health services. Such engagement serves to ensure that the right services are utilized at the right times in the right settings and that inappropriate services are avoided.

- 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? This would be ideal as consumers are best served by providers with whom they already have relationships. While a system level view centers on services, the view from the consumer's perspective centers on the relationship he or she has developed with a provider or even with a health plan. Every instance of a change of provider or transfer in plan is a potential disruption in engagement and, in turn, the possibility that the consumer becomes alienated from coordinated care.

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

We will likely need to recognize that there will be limits to this, as networks become unavailable—just as is the case now with private insurance. If the consumer whose circumstances change is lucky enough to be in a CCO that serves both market-rate insureds and Medicaid consumers, then he or she should certainly have that option.

However, in cases in which a consumer must move from one coordinated care entity to another, the EHR will be useful in ensuring that clinical information follows him or her. Further, providers will need to be encouraged and supported to collaborate with one another as consumers move from one to another.

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

Consumer handbooks, consumer rights inclusive of a grievance process, HFS-convened consumer advisory boards, consumer involvement on the coordinated care organization's board, satisfaction surveys, a 1-800 number for complaints with follow-up between HFS and the provider, and ongoing evaluation of complaints or drop-out rates all will serve to ensure that consumer satisfaction is taken seriously by the provider organization. Ultimately, appeals rights must include the right of the consumer to select an alternate plan though this should not be the first step.

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

- 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?

Heartland Health Outreach is assertively exploring how to establish its own Medicaid Accountable Care Organization (ACO) and has secured funding from the Michael Reese Health Trust to do so. HHO has a significant history of coordinating care for many of Chicago's most vulnerable residents including individuals experiencing homelessness and those with multiple chronic health conditions. Impacting our decision is our mission-based intention to engage and serve those most marginalized by poverty and social isolation. As a result, the basic elements of coordinated care have been organically woven into our service delivery system. As we continue to further explore this opportunity, we are engaging in an analysis of our fiscal and information management needs necessary to take on such risk management. In addition, we are identifying the range of specialty and other services we will need to incorporate to adequately address the comprehensiveness of our care continuum.

- 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.

HHO employs a variety of evidence-based and other best practices to engage underserved people into services, assess their needs, link them to adequate services and supports, and encourage motivation for change. We utilize such techniques as street outreach; coordinated, integrated intake procedures; integrated bio-psycho-social assessment; interdisciplinary staffing and team approaches; community-based support services; and supportive housing. In addition to this, we employ systems integration efforts aimed at addressing systemic barriers that prevent full participation of our program participants in the services and supports they need to maintain stability in the community. We also have a history of braided funding that includes HRSA (FQHC and Ryan White), MRO, HUD, private funding, city funding, and state-funded capacity grants. Our mission-based agenda has centered on drawing from various funding streams to create as seamless a system of care as possible for vulnerable individuals with complex health needs.

- 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?

No. We are, however, interested in a Medicaid ACO model.

- 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?

See 8. a)

- 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?

HHO currently serves approximately 15,000 people experiencing homelessness in the Chicago area. We are working to assess how many of our population could benefit from care coordination. We are positioned to work with this vulnerable population – particularly those who have multiple chronic conditions.