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Illinois House Committee on Health Care Availability and Accessibility
Friday, August 12, 2011

Comments on Medicaid payment compliance

Chairperson Mary Flowers, Vice Chairperson Karen May, Republican spokesperson
Dennis Reboletti, members of the Committee

I am Vincent Keenan, executive vice president of the Illinois Academy of Family
Physicians, the professional medical specialty association for 3800 Illinois family
physicians. Thank you for the opportunity to speak today on Medicaid payment
compliance.

Building on the success of Illinois Health Connect and Your Healthcare Plus

Illinois has had five years of positive experience using a Patient Centered Medical
Home (PCMH) as the framework for the Medicaid program's primary care case
management project (known as Illinois Health Connect) and the Medicaid program's
chronic disease management program (Your Healthcare Plus). See Case Statement on
both programs, www.iafp.com/PR/CaseStatement.pdf

In 2006 when Illinois Health Connect and Your Healthcare Plus began, the Medicaid
program was primarily a payment system based on a fee-for-service model. As 1.5
million Illinoisans were enrolled in Illinois Health Connect in 2007, most patients had
their first opportunity to choose or be assigned to a PCMH. The Medicaid program had
begun to move from merely a payment system towards becoming a health system. At
present, 1.9 million Illinoisans are enrolled in Illinois Health Connect. The clinical results
of the program showed improvement as Illinois Health Connect matured.

	2007	2008	2009
Children ages 0-3 at least 1 objective Developmental screen	25.5%	29.3%	36.1%
Women ages 42-69 receiving at least One mammogram in past two years	37.45%	37.36%	38.86%
Adolescents receiving check up Every other year	50.84%	51.51%	54.11%

Your Healthcare Plus engaged 280,000 Illinoisans in chronic disease management, using
a more intensive model than had been experienced with chronic disease management
programs in other states. An Illinois-based field staff of more than 180 professionals
(such as nurse case managers, social workers, behavioral specialists, and nurse disease
specialists) not only provided telephone-based intervention but would visit with
patients to create care plans.

As the program matured the financial results were quite impressive. The figures below show savings as measured against expected costs given the trend of rising Medicaid expenses for both programs, state fiscal years 2007 through 2010 (four years)

Illinois Health Connect: \$431 million

Your Healthcare Plus: \$569 million

Total savings: \$1 Billion

From the perspective of Illinois' family physicians, the strides made by the Illinois Health Connect and Your Healthcare Plus projects, are wonderful building blocks for taking the next steps of moving from 280,000 persons having some coordinated care (through Your Healthcare Plus) to perhaps 1.5 million persons having coordinated care by 2015 (with the addition of more Illinoisans covered by the Medicaid with the introduction of the Health Insurance Exchange).

Patient Centered Medical Home is key to future of healthcare and is model for changed payment system

The Patient Centered Medical Home model espoused by all the primary care medical specialties (see the Patient Centered Primary Care Collaborative, www.pcpcc.net for details) should be the first step for the Illinois Department of Healthcare and Family Services (HFS)' Coordinated Care Program. Director Julie Hamos has announced the Innovations Project, as the next step for HFS. IAFP recommends that HFS build on the framework established by Illinois Health Connect, which has some basic requirements for medical home, and a blended payment methodology (fee-for-service, care management and performance bonus). The next step would be to introduce levels of "medical homeness", such as those provided as PCMH designation by National Committee on Quality Assurance, <http://www.ncqa.org/tabid/631/Default.aspx> Payments could be tiered based on level of "medical homeness" achieved. While IDHFS could develop its own "medical homeness" scale, IAFP would recommend that HFS instead support PCMH designations by the following organizations (NCQA, Joint Commission <http://www.jointcommission.org/accreditation/pchi.aspx> , URAC http://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx and AAAHC <http://www.aaahc.org/eweb/dynamicpage.aspx?webcode=mha>). The requirements for payment for "medical homeness" need to be explicit but the tiering system would be expected to have requirements that increase over time.

IAFP agrees with the Affordable Care Act's intention to at first stay away from coordinated care coverage for specific diseases. IAFP does not believe in the concept of medical homes for specific diseases or organs. There must a "whole-person" approach which "Patient Centered" Medical Home implies. The American College of Physicians has published a position paper on medical home neighbors, which describes the relationship of subspecialty care with primary care in the medical home. This concept needs to be explored further and can be found here, http://www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf Also, HFS should create incentives and means for different sites of care to collaborate (such as emergency rooms and primary care practices).

Other suggestions for changing the payment mechanism for Medicaid

The Medicaid program already has experience in paying for health care outcomes measured against evidenced-based practices with the Illinois Health Connect bonus payments. In July 2011, for the third year in a row, primary care practices received bonuses based on achieving or exceeding HEDIS Medicaid measures. There are only a few measures (mostly preventive services). IAFP suggests that HFS expand the measures for FY 2013 to a core set of

about 25-30 measures and build from there on an annual basis. IAFP suggests convening the providers to create measures and ensure they are evidence-based and reliable measuring is feasible. The provider work group would develop the core set of measures in FY 2012 and add measures annually. In the commercial sector, health plans and medical groups have achieved reasonable success in starting with a core set and incrementally adding measures.

IAFP proposes that HFS set as a goal the following blended payment for FY 2017 (50% fee-for-service, 40% care management and 10% performance bonus).

The role of federal Electronic Health Records incentives

IAFP believes that the current incentives for “meaningful use” through the Medicare and Medicaid programs are such that supplements by HFS for practices would not move primary care practices faster towards adopting, implementing or upgrading electronic health records. The marketplace is moving too quickly to set realistic dates for when all practices should be electronically enabled. HFS is in a great place to monitor how electronic health records are being adopted and the development of the state Health Information Exchange will have a great influence on how quickly practices convert. A point of information, about 60-70% of family physicians report having an electronic medical/health record. If there is a focus for HFS, it would be to enable communications between sites of care (such as Emergency Room and primary care physicians) utilizing electronic capabilities.

Some final thoughts

IAFP strongly suggests that the Coordinated Care Program needs to be solidly based on the Patient Centered Medical Home. Special projects could focus on particularly vexing issues, such as transitions of care, optimal emergency room use, and behavioral health. However, the special projects need to support the concept of PCMH, not serve as a means of “carving out” care from primary care providers, as was done in the past with unsuccessful results.

Data from the Illinois Health Connect project seems to indicate that clinical quality outcomes for the 1.9 million clients in Illinois Health Connect is better than clinical quality outcomes for the 200,000 Medicaid clients enrolled in managed care plans. A recent Commonwealth Fund report shows that publicly traded health plans underperform in terms of quality of care and administrative expenses when compared to both non-publicly traded and provider-sponsored plans. <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2011/Jun/Financial-Health-Medicaid-Managed-Care.asp> IAFP advises that continuing to focus on support of the Patient Centered Medical Home model would help to ensure continuity of care.

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