AIDS FOUNDATION OF CHICAGO

A SOURCE OF HOPE. A FORCE FOR CHANGE.

December 5, 2014

Julie Hamos, Director
Illinois Department of Healthcare and Family Services
201 South Grand East
Springfield, Illinois 62763

RE: Comments on draft Health Home Concept Paper

Dear Director Hamos

Thank you for the opportunity to comment on the Illinois Health Home concept paper. We sincerely appreciate the work of the Illinois Department of Healthcare and Family Services (HFS) to improve care coordination and outcomes to vulnerable populations.

The mission of the AIDS Foundation of Chicago (AFC) is to lead the fight against HIV/AIDS and improve the lives of people affected by the epidemic – which also includes other chronic health conditions. Founded in 1985 by community activists and physicians, the AIDS Foundation of Chicago is a local and national leader in the fight against HIV/AIDS.

As you finalize the health home proposal, please consider the following:

1) Explicitly include HIV as one of the conditions that can be managed in a health home. We urge HFS to explicitly name HIV as one of the chronic conditions that can be managed in a health home. It is too much of a gray area to assume that HIV is covered as a chronic condition or will meet the scoring criteria of the 3M Clinical Risk Grouping software. The 2010 State Medicaid Director letter[1] on health homes clearly stated that HIV can be included as one of the health home chronic conditions, and we urge HFS to take advantage of that opportunity. Doing so would send a message to MCOs that people with HIV are a priority population.

2) Include HIV viral suppression as one of the health home quality measures. The most important and measureable outcome of successful HIV treatment is helping an individual become virally suppressed – in other words, nearly eliminating HIV from their bodies with medication. The 2014 Medicaid Adult Core quality measures include HIV Viral Load Suppression (Measure HVL-AD, the percentage of Medicaid enrollees age 18 and older with a diagnosis of HIV who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year). The quality measures proposed in the concept paper to monitor Health Homes do not include any HIV quality measures, and fail to reflect the value and cost-savings of enhanced HIV services. Health homes should be required to report on this outcome for their HIV population.

[1] Center for Medicaid and CHIP Services, Health Homes for Enrollees with Chronic Conditions, November 2010, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf, accessed 12/3/14.

In AFC's Ryan White case management system, 80% of clients are virally suppressed. Only 40% of people with HIV in Chicago are virally suppressed.[2]

3) Include in health homes people with HIV who under-utilize care to improve individual health outcomes and reduce new HIV cases. Although modern anti-retroviral therapy can help people with HIV live near-normal lifespans, too many highly vulnerable people with HIV are not getting any medications. We urge HFS to require MCOs to include in health homes people with HIV who are *under-utilizing care* HIV care. We reviewed nearly a year of Illinois HIV claims data in partnership with one Illinois MCO, and found that nearly half of the plan's diagnosed HIV population was taking medications intermittently or not taking HIV medications at all. We know from 25 years of Ryan White Program services that outreach, medication adherence counseling, face-to-face contacts, referral tracking and connections to community and social support services (including housing) help people with HIV to achieve viral suppression. These services are all included in health homes.

People with HIV who are out of care are missing the life-extending benefits of HIV medications, and will eventually have in high health care costs that result from an AIDS diagnosis. Just as importantly for public health and the state's long-term health care spending, linking people with HIV to treatment will also Illinois reduce new HIV cases. Nearly iron-clad scientific evidence shows that people with HIV who are virally suppressed have a 96% lower risk of transmitting HIV in the community.[3] Illinois will save an estimated $380,000 in lifetime HIV medical care along for each HIV case prevented.[4] For those HIV-positive individuals either not in care or not consistently receiving and taking their medication, it is of concern that their 3M CRG score might not stratify them as eligible to be in a Health Home.

4) Standardize care coordination definitions and reporting among MCOs. AFC is in various stages of contract negotiations with six Illinois MCEs. We urge HFS to adopt standard service definitions and service delivery models so community-based organizations can work effectively with multiple MCOs. Examples include:

- Specify what care coordination services an MCE can delegate to a contractor and what can be co-managed. One MCE is unwilling to sub-contract AIDS Waiver case management to AFC because 100% of their files are audited monthly by HFS to ensure they have met contract requirements. This HFS requirement makes it too unwieldy for the MCE to delegate this service to AFC. However, this is exactly the type of enhanced service that AFC has been providing to this population for over two decades. This MCE is actually disincentivized to work with AFC as a community partner for AIDS Waiver services.
- Standardize care coordination definitions: HFS should work with MCEs and CBOs to define services such as care coordination encounters, data reported to the plan and other elements.

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[2] HIV/STI Surveillance Report, Chicago. Chicago Department of Public Health, December 2014, p. 5. http://www.cityofchicago.org/content/dam/city/depts/cdph/HIV_STI/2014HIVSTISurveillanceReport.pdf accessed 12/4/14.

[3] Cohen, Myron S., et al. *Prevention of HIV-1 Infection with Early Antiretroviral Therapy.* 2011 New England Journal of Medicine 493-505: V365, no 6, http://www.nejm.org/doi/pdf/10.1056/NEJMoa1105243.

[4] *HIV Cost Effectiveness,* U.S. Centers for Disease Control and Prevention, January 5, 2012. Accessed 12/3/14 from www.cdc.gov/hiv/topics/preventionprograms/ce/index.htm.

Establishing common care coordination definitions and reporting will allow CBOs work efficiently with multiple MCEs. We ask HFS to establish a workgroup to determine these areas

- Clarify that CBOs providing care coordination need not be certified Medicaid providers. Many experienced CBOs (including AFC) that have effectively served vulnerable populations are not able to become Medicaid providers. AFC, for example, does not offer Medicaid-reimbursable services. Therefore, we are only able to establish vendor relationships with plans.

5) Fund technical assistance and learning collaboratives for CBOs to build capacity for work with MCOs. A staggering amount of work and high level of sophistication is needed for a grants-based organization to transition to an encounter-based, outcomes-focused business model. For the past year and a half, AFC has worked incredibly hard to secure contracts with managed care organizations to provide care coordination services for people with HIV and chronic diseases. AFC has hired a full-time staff person, used consultants, and relied on hundreds of hours of pro-bono legal counsel reviewing contracts. This level of investment is not achievable for a smaller CBO.

6) Set a clear expectation that Health Homes must include CBOs on the care team. HFS should specify in contracts with MCOs that Health Homes must include CBOs as members. Established CBOs have trusted relationships with community members that will help Health Homes find and engage members and provide enhanced services.

7) Recognize outreach as an essential service that must be adequately reimbursed. The first step in providing Health Home services is often finding a member. The work involved in outreach (travel time to a relative's home or to a member's last known address, and finding homeless members, for example) is real and must be reimbursable to be effective. New York, for example, pays a PMPM outreach and engagement rate for up to three months while an individual is located.[5] New York specifies which services are reimbursable during the outreach and engagement phase. Illinois already recognizes the importance of outreach for mentally ill populations, and pays for outreach under Rule 132. We urge HFS to establish clear outreach standards for plans to meet that mirror best practices identified by other states, including New York.

We appreciate the opportunity to provide comments on Health Homes and will help in every way possible to help HFS to develop the health home model. Our contact information is below.

Sincerely,

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[5] New York State Medicaid Update, "Introducing Health Homes," p. 8. http://www.health.ny.gov/health_care/medicaid/program/update/2012/april12muspec.pdf accessed 12/3/14.