Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
January 8, 2013

401 S. Clinton Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Members Present
Kelly Carter, IPHCA
Art Jones, M.D., LCHC & HMA
Margaret Kirkegaard, M.D., IHC, AHS

HFS Staff
Julie Hamos
James Parker
Arvind Goyal
Sherri Sadala
Jessica Hoff
Sameena Aghi
Andrea Bennett
James Monk

Members Absent
Kathy Chan, IMCHC
Ann Clancy, CCOHF
Vince Keenan, IAFP
Diana Knaebe, Heritage BHC
Jerry Kruse, M.D., M.S.H.P., SIU SOM
Mike O'Donnell, ECLAAA, Inc.
Indru Punwani, D.D.S., M.S.D., Pediatric Dentistry
Edward Pont, Chairperson, M.D., IL Chapter AAP
Janet Stover, IARF

Interested Parties
Greg Alexander, Community Care Alliance
Karen Batia, Together 4 Health
Julie Billingsley, Magellan
Kathy Bovid, Bristol-Myers Squibb
Kristen Braun, Macon Co. Care Coordination
John Bullard, Amgen
Carrie Chapman, LAF
Matthew Collins, HealthSpring
Mike Cotton, Meridian Health Plan
Delia Davis, Access
Andrew Fairgrieve, HM
Jennifer Filicky, Heartland Alliance
Paul Frantz, Wellcare
Teresa Garate, NFS/Be Well
Donna Gerber, BCBSIL
Susan Gordon, Lurie Children's Hospital
Barb Haller, IHA
Barbara Hay, FHN
Marvin Hazelwood, Consultant
Teresa Hursey, Aetna
Judy King
Keith Kudla, FHN
Mike Lafond, Abbott
Phillip Largent, Consultant
Dawn Lease, Johnson & Johnson
Jane Longo, CCHHS County Care
Marilyn Martin, Access Living
Mora Martin PHRMA
Deb Mathews, UIC-DSCC

Interested Parties Continued
Susan Melczer, MCHC
Diane Montanez, Alivio Medical Center
Karen Moredock, DCFS
Mike Mroz, Be Well Partners in Health
Kristen Pavle, HMPRG
John Peller, Aids Foundation of IL
Jennie Pinkwater, ICAAP
Jay Powell, AmeriHealth Mercy
Mary Reis, DCFS
Carla Robinson, Consultant
Sam Robinson, Canary Telehealth
Joel Roth, U of Chicago Medicine
Dee Ann Ryan, Vermilion Co. MHB
Amy Sagen, U of IL Health system
Christy Serrano, Ounce of Prevention
LeAnn Shoemaker, Macon Co. MHB
Sharon Sidell, Be Well Partners in Health
Bernadine Stetz, Molina Healthcare
Cynthia Waldeck, Heartland Alliance
Nicole Willing, Mylan
Brenda Wolf, La Rabida Children's Hospital

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I. Call to Order

Dr. Art Jones chaired the meeting and called to order at 10:05 a.m.

II. Introductions

Committee members and HFS staff in Chicago and Springfield introduced themselves.

III. Director's Report

Director Hamos stated that since the last meeting the Department had published the Care Coordination Roll-Out Plan for January 2013 through January 2015. A copy was provided and is found online at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/010813_maccc_handouts.pdf

The Department had made the awards to the 6 CCEs for the Innovations Project and 8 MCOs for the dual-eligibles project and now has a robust care coordination roll-out plan. HFS looked at population density in the state and identified care coordination regions. The Integrated Care Program covers the suburban Cook and collar counties for non dual-eligible seniors and persons with disabilities. Under the Innovations Project, there is coverage in the Chicago area and in the central Illinois region. The Department is looking at adding Rockford, Quad cities, and Metro East regions. HFS plans to expand enrollment under the Affordable Care Act (ACA) beginning October 2013 and services to be available starting January 2014. New members would be enrolled in care coordination.

The first state legislative hearing on the newly eligible population under the ACA was held January 7th. There is a bill that has been introduced in the House and the Senate. A coalition of 150, or more, organizations supporting this legislation are talking to legislators statewide. It will be a challenge to get this bill passed.

HFS anticipates about 500,000 new enrollees in Medicaid with two-thirds being the newly eligible. These are mostly adults without dependent children. There is a generous federal match of 100% for the first 3 years and 90% match over time. There is a bill amendment that ceases this category of eligibility if the federal funding drops below 90%. Information about the bill will be found on the HFS website under the ACA section of the site (http://www2.illinois.gov/hfs/PublicInvolvement/AffordableCareAct/Pages/default.aspx). The Department will also have the twelve point implementation plan to help explain why HFS wants to do this now. The Department hopes that this new group could be added at the same time that the ACA coverage begins.

HFS anticipates a big national marketing push to get people to sign up through our partnership exchanges with assistance from both navigators and providers. People will sign up and many with income at or below 133% poverty will be diverted to Medicaid. The State needs to be ready. The Department needs your support to tell legislators that this needs to be acted on now.

Q: Dee Ann Ryan asked if there has been discussion about targeting other high cost populations like children with severe behavioral health needs.
A: James Parker, Deputy Director of Operations, advised that HFS has a solicitation out now for children with complex needs including behavioral health needs. What you would see on the care coordination roll-out plan is that all children would be going into care coordination. He added that there has been some preliminary discussion with DCFS on some possible alternatives for mental health services for DCFS children. Director Hamos added that the Department would like to try a demonstration project with a managed care approach for those populations.

Q1: Dr. Judy King asked about the SMART Act and what was being done to improve birth outcomes.
A1: Regarding birth outcomes the Department is developing programs around high-risk moms with sister agencies, DPH and DHS. A design consideration is not to duplicate and to consolidate services provided. DHS is working on a project to use their case management program in a more targeted way. Executive staff would be discussing this next week.

Q2: What is being done for persons moving from incarceration to the community to ensure they have medical coverage?
A2: The Department doesn't terminate Medicaid when persons are incarcerated, although HFS is not allowed to pay their bills while in prison. The most important component is that the person has the medical card when released from jail in order to access health care especially psychiatric drugs. There is no system in place to track where people are once released. Under the SMART Act Illinois has begun the Enhanced Eligibility Verification (EEV) system and there will be a much greater focus on completing the annual redetermination to ensure eligibility. As part of that, the Department has to be able to find people. It is possible that persons would be terminated if we can't find them. What needs to happen is having someone standing at the front door of that jail to connect released persons to a CCE for a needs assessment.

Q3: What is HFS doing about increased payment to primary care providers (PCPs) and increasing access?
A3: HFS will begin to pay PCPs at the Medicare rate in January and will need to make an announcement about the process. Payments will be subsequent add-ons made perhaps quarterly. When a claim is initially processed it will be paid at the state rate and the add-on will come later. HFS needs to segregate the initial payment so the subsequent payment can be made to get it to the 100% rate. This is complicated by the fact that HFS has some codes that have the MCH payment. Also, the HFS definition of a PCP is different from the Feds. HFS is looking at Michigan's provider enrollment which includes an online enrollment system modified to collect the information needed for the add-on payments. HFS is trying to piggy-back onto that system. Because of this, HFS hasn't sent anything to providers about how to register for those payments.

Q: Dr. Jones asked if the Department will be adjusting the MCO premium to reflect that also.
A: Based on encounter data, HFS will make a supplemental payment to MCOs with the file that shows how much payment goes to which doctors.

Q1: It is true that there will be another round of CCE/MCCN solicitations in the spring?
A1: There were additional proposals that came in beyond the 6 proposals that were approved. The Department extended the offer to the additional entities, and is working with them to modify their proposals for possible approval. The Department does not intend to offer a new solicitation at this time.

Q2: Is the department open to receiving a short white paper on different ideas that are not necessarily a response to the solicitation, but fall within the broader framework of a CCE or MCCN targeting a population with a specific disease and have a higher coverage cost?
A2: The Department has tried to stay away from disease specific proposals. If you focus on individuals with a specific disease, you would still also have to coordinate all of their care. That said, targeting a population with high cost condition is something the Department would be interested in.

Q: Kelly Carter asked if the Department could announce which MCOs might be approved for the different geographic regions for the ICP type expansion in the care coordination roll-out plan.
A: The anticipated SPD coverage in the Central Illinois region would be the same as the MMAI plan using Health Alliance and Molina with a small exception that Meridian health plan will operate in Peoria, Knox, Stark and Tazewell Counties. In the Rockford area, you would see Aetna, Centene and the Community Care Alliance Initiative. For the Quad Cities and Metro East regions, the Department can't say as yet but will get something out once the decision is made.

IV. Review of October 2, 2012 minutes

There was not a member quorum at the meeting so the minutes could not be approved. There were no comments made on the October minutes.

V. Update on Duals Project

Status of Solicitation

Mr. Parker stated, as mentioned earlier, the Department has made awards to eight companies. The six awardees in the Chicago area are Aetna, Centene, HealthSpring, Humana, BCBSIL and Meridian. The two awardees in Central Illinois are Health Alliance and Molina.

Dual Medicare/Medicaid Care Integration Financial Model Project

HFS hopes to sign the final Memorandum of Understanding (MOU) with the federal CMS by the end of January. The MOU is the instrument that officially awards the project in Illinois. Otherwise HFS is working with the plans to get the system up and running so they will have their networks and be able to pass readiness reviews in the summer.

The Integrated Care Program Phase 2 is set to launch on February 1st. Phase 2 adds Long Term Supports and Services (LTSS) for the 40,000 enrollees managed by Aetna and IlliniCare in the Cook County suburbs and collar counties. On January 24th, there will be a town hall meeting at JRTC as well as a webinar to present the two companies' vision and how this next phase will work. The meeting is for all types of LTSS providers, and the public, both in the service area and downstate. HFS would like providers, and the public, to attend and hopes for a full and robust discussion of questions, issues, operational philosophy, experience and background.

Director Hamos stated that with all the projects and new entities going on with coordinated care, the Department would like to find a new name that Medicaid clients could say. For example like TennCare for health insurance in the state of Tennessee or CountyCare for health insurance in Cook County. Participants were encouraged to make suggestions for a name for the Illinois managed care programs.

Q: Will HFS will put something on its website that will show what plans cover specific geographic areas.
A: Yes, This will be developed once contracts are signed. Right now the only contracts in place are the ICP contracts with Aetna and IlliniCare. There will be a roll-out pretty quickly and all that will be on the website. There is also a one page description of what this is about and the 3 types of managed care entities.

VI. Care Coordination Entities Presentations

Mr. Parker stated that the Department is excited to have the CCEs and MCCN representatives here today. He stated that HFS was impressed with how far along the entities are to getting up and running and the comprehensiveness of their views on what they are trying to do.

Each of the four entities represented gave a brief presentation of their background and plans for their innovation program. Participants were encouraged to ask questions after each presentation. A summary of each presentation is shown below. Additional information can be found online at http://www3.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=2&RecNum=10634

Be Well Partners in Health - Sharon Sidell, Director of Psychiatric Services at Methodist Hospital of Chicago presented along with her partners, Teresa Garate of Neumann Family Services and Mark Mroz of MADO Healthcare Centers. Be Well Health's partners include: Bethany Homes and Methodist Hospital of Chicago and Norwegian American Hospital; MADO Healthcare that offers short and long term, skilled and intermediate residential, and; Neumann Family Services, a community service placement organization serving persons with developmental disabilities and the MI population.

Ms. Sidell provided a history of the organization describing MADO reaching out to Neumann Family Services; Methodist hospital reaching out to MADO to place intensive outpatient services in a residential care facility; Norwegian American creating a coordinated care network for patients in the hospital, and; Neumann working with Methodist Hospital to set up the health home for the developmentally disabled. Be Well Partners includes a network of associates that are groups with which they are working on projects and collaborators that are providers within the community including transportation, pharmacy, therapeutic rehab services and others.

The Be Well innovation is due to three things. It has two niche hospitals where behavioral medicine is a significant part of their revenue and they are committed to reducing hospitalization and ER visits for the seriously mentally ill. MADO is committed to transition folks living in an ICF to the community. Finally Neumann Family Services is committed to the coordinated care model within their system of services.

Community Care Alliance of Illinois (CCAI) -The presentation was made by Greg Alexander, CCAI President. CCAI is a Managed Care Community Network (MCCN), which is a not-for-profit health plan that is provider owned. It is a subsidiary of Family Health Network (FHN), which has served the TANF population over the past 17 years. CCAI came together as a community partnership anticipating changes that were occurring in Medicaid. The partnership includes various entities led by Access Living of Chicago, Health and Medicine Policy Research Group (HMPRG) and Sinai Health System. FHN became involved as they offered the operational and financial capacity to bring this entity to life.

CCAI borrows from a successful model pioneered by Dr. Robert Master from the Commonwealth Care Alliance in Boston. It relies heavily on nurse practitioners and a team based approach. CCAI has over 45 hospitals and 7,000 providers in the Chicago and Rockford areas. It is a capitated full-risk model which allows for a person-centered consumer-driven integrated model of care that encompasses medical and behavioral health as well as LTSS. It will operate much like the Integrated Care Program with a heavy emphasis on health and wellness. CCAI will provide specialized primary care training in the area of disability competency as well as training on their model of care.

CCAI will be using nurse care coordinators and LTSS coordinators to provide support to the primary care physician who may already be covering that member. Each member will be enrolled with an inter-disciplinary care team that will do a health risk assessment and care plans addressing six domains of care. Service may be provided in enhanced care sites which work with a patient's existing PCP and help ensure continuity of care. There are also Centers of Excellence that are entities like Rush Hospital and the Rehab Institute of Chicago to provide highly specialized care for members with complex needs.

One of CCAI's most innovative elements is for members to have an anchor medical home, or health homes, which are fully disability competent, and are in large part, at hospitals that will work with the inter-disciplinary care teams co-located on-site. Nurse practitioners will also be able to deliver some care in the member's home.

Macon County Care Coordination (MCCC) - Kristen Braun and LeAnn Shoemaker with the Macon County Mental Health Board presented. MCCC proposes to run a healthcare plan with a bio-psycho-social emphasis. The Macon County population is approximately 114,000 with 80% located in Decatur. The base population for the CCE is about 1,400, but will expand. The Macon County Mental Health Board is the lead entity. The core collaborators include Decatur Memorial and Saint Mary's Hospitals, the community's major public health and substance abuse provider, Heritage BHC: the community's FQHC, Community Health Improvement Center, and SIU Family Practice. There is also an MOU with their long term care facility which is an IMD facility.

The Macon County Mental Health Board, also referred to as a 708 Board, is a unit of county government that manages money from local property taxes to fund prevention and treatment services for individuals with mental health, substance abuse, and those who have a developmental disability diagnosis. The 708 Board also manages three housing corporations and a Child and Family Connections contract.

MCCC will utilize the health home concept to target and serve high-risk, high cost individuals. Triage and screening will be incorporated to identify those individuals. One of the objectives is to develop individual care plans and assist the member by improving self management skills.

MCCC will work to decrease the current fragmentation in the system by: increasing provider information sharing, implementing and increasing care coordination in transitional care, building upon and increasing peer review and teamwork within the network, increasing access to appropriate levels of care, facilitating

communication in cross treatment settings, and increasing appropriate enrollee identification using passport cards that both hospitals have agreed to enter into their systems. Teams will include APN team leaders, mental health and substance abuse specialists, and navigators helping with linkages and outreach.

MCCC is looking at extending the target population and at exploring creation of a centralized electronic care coordination record and sees care coordination as a viable option in providing care.

Together4Health (T4H) - The presentation was made by Karen Batia, Executive Director of Heartland Health Outreach and Vice President of Heartland Alliance for Human Needs & Human Rights. Together4Health is a brand new provider network in the Cook County area put together by Heartland Health Organization, Inc., and is a separate LLC owned by 34 different organizations that include 5 hospitals, many FQHCs, pharmacies, behavioral health providers, and housing providers. T4H also has organizations that support the safety net providers with folks like the AIDS Foundation, the Corporation for Supportive Housing and the Treatment Centers for Safe Communities (TASC).

The intent of the T4H network is to form regional health home hubs to wrap-around the services for individuals with serious mental health illnesses and multiple chronic health needs. The goal is to continue to leverage services that folks are already receiving, and go after individuals that are the highest users of Medicaid through an integrated care plan that promotes physical, mental, and social well-being, while improving access to care. T4H will do a health engagement assessment to determine a person's ability to manage their illnesses. The Innovations Project brings a unique focus on serving the hard to reach populations living in severe poverty and moving in and out of homelessness.

The care coordination team within each of the health home hubs will include a nurse, a mental health specialist, and community health workers, who will be in people's homes to help access services in their neighborhood and help that person navigate what is needed to keep them out of the more expensive care.

T4H plans to connect their different partners, which have multiple health information systems, to a centralized data system called AMALGA. This is critical to track the program from a data surveillance perspective and obtain access to real time data about where people are being seen and what services they are receiving.

Payment reform mechanisms are important. It would be better for T4H to move into a full risk model and use money flexibly for services that are effective but outside the current Medicaid rules. As a provider led network this is not possible to do yet. With care coordination fees, T4H will use the next few years to work in partnership with HFS to look at opportunities to try some different flexible payment structures.

Q: How are the CCEs going to increase access to specialty care?
A: T4H members will access care in a variety of ways. Owners are incentivized to connect people when appropriate. T4H is also using Telehealth for direct services and care coordination.

Q: Could you talk more about payment reform?
A: There are a number of opportunities through the ACA for the health home option and through the Innovations Project grant structure. There are three ways to finance CCEs; these are care coordination fees, the cost savings sharing model that allows CCEs to used saved money for services not normally covered under Medicaid but deemed essential, and the opportunity to request inter-governmental transfers where HFS would discuss with sister agencies using dollars outside the Medicaid system for services that are already touching CCE enrollees and using those dollars flexibly.

Q: What is the status for shared savings in the complex children's RFP?
A: HFS continues to work with Federal CMS on what their tolerance is for matching shared savings. The concept is HFS would pay out money that did not need to be paid out because it was saved. As a payment, HFS would seek federal match. The shared savings model would likely look like the ACA model.

Q: Are the CCE providers going to be charging copays?

A: T4H will follow the current Medicaid rules when providing Medicaid services.

VII. Outpatient ER Usage

A handout, "Outpatient Emergency Room Usage by Month, Pre- and Post- SMART ACT Changes" was provided and online at http://www2.illinois.gov/hfs/SiteCollectionDocuments/010813_maccc_handouts.pdf

Mr. Parker advised that HFS had been asked to track ER usage to see if there is an increase as a part of implementing the SMART Act. Right now the Department is not seeing an increase. He cautioned that because of the claim lag in the past, any numbers for the recent months should be considered incomplete. One of the changes under the SMART Act was to shorten the billing period from one year to six months so the numbers should be more complete now than they would have been.

The chart column heading, "ER Users - Higher APL" refers to Ambulatory Procedure Listing (APL). For outpatient services, HFS pays only one APL. Emergency room service is an APL service. When there are multiple services, HFS pays only the highest one. If a person goes to the ER and has a procedure more costly than an ER visit level 1 or 2, it is not listed with an ER code. The chart uses the Higher APL category to capture the ER visit.

There were suggestions by participants to modify or enhance the data by reporting:

- Encounters as per thousand recipients to control for changes in the population
- By season as encounter levels may vary by season
- Data broken down by basis of eligibility or age group
- Data broken down by geography or diagnosis or specific reason for going to the ER
- Data over more than a year to allow for better trend analysis
- By zip code of the patient or the ER site

Dr. Jones noted that looking at ER utilization is a good way to look at access to primary care and how well people are being care managed.

Mr. Parker advised that the Department could report rate per thousand, children versus adults and more pre-SMART Act months. One thing HFS has been asked about and will report on is dental diagnosis for adults at the ER. The Department is also looking at ways to enhance its ability to analyze data that doesn't come easily in a spreadsheet by using new technology or reporting by personnel.

Dr. Kirkegaard stated that she believed that one of the questions that this data was trying to sort out was the impact of copays in the emergency room on both deterring inappropriate ER access and possibly impacting appropriate access. We know there is a high variation in how primary care doctors are enforcing the requirement to collect copays. She was wondering if any of hospital representatives or partners has a sense of how hospitals are collecting the ER copay from patients.

Ms. Sidell stated that at her two hospitals, they follow the protocol to make sure a person can't pay the copay before writing it off. Otherwise they expect the patient to make the copay.

Q: Dr. King asked what instructions are given to hospitals on how to work out patient referrals when they are unable to make the copay. She stated that under the SMART Act, people now pay more for copays. Her understanding is that after the ER assesses that the person has an emergency, before they can charge the copay, they must know of a place that the person can go to get care.
A: There are two different provisions in federal law that allows the Department to impose copays, Section 1916 and Section 1916A of the Social Security Act. The provision where you are charging higher copays is 1916A. The Department has opted to go with nominal copays covered under Section 1916. The provision that requires referral to another site with a lower or no copay does not come into play with the nominal copays that the Department charges.

Director Hamos added that hospitals are supposed to go on the HFS MEDI system to find the medical

home for that person and refer them. She asked if anyone knows if this is happening. Dr. Kirkegaard stated that IHC has worked extensively with the hospitals to encourage them to do that but the feedback has been that it is an onerous administrative process that they can only barely do.

Director Hamos stated that this is a process that providers will have to grapple with as the Department will be discontinuing sending out the monthly medical card. When the provider goes in to check eligibility they will also need to look at the information on the person's medical home.

Dr. Jones shared that the plan at Medical Home Network (MHN) has an IT solution that is web-based. As soon as a patient registers in the ED or hospital unit, a real time alert is sent to the primary care home and is also fed into the screen that the ED doctor is working on. Each ER has integrated this information into their work flow so that when ER staff register a patient, information pops up and they can get a print out with a picture of the medical home, directions, PCP name and business hours. This process hasn't happened yet but will start once the flag is put on by HFS.

This system may allow care coordinators to make contact with a hard to reach member. Participating hospitals are Rush, Cook County, Sinai, Saint Anthony, Holy Cross, La Rabida and three of the Advocate hospitals. Mercy and UIC plan to go on the system, and University of Chicago is looking at the system. As the network expands it will make it possible to see if an MHN member goes to a location other than the preferred hospital. It should be very easy for the ED to find information.

Ms. Batia added that we need to incentivize hospitals to make that connection as part of a systemic solution to providing more effective care coordination.

VIII. Affordable Care Act and the Future

Dr. Jones asked about the RFP for complex children in which HFS stated that the CCEs needed to meet the criteria for 2,703 health homes. He asked if the Department could tell the group about when that might be implemented and where that is in the process.

Mr. Parker reviewed that the enhanced federal match for health homes is time limited to eight quarters. If you don't have all your health homes up and the clock starts, then you will not get as much match. Secondly, CMS won't approve a state plan match unless health homes are set up for all the different categorically eligible people. You have to have health homes for the duals, the AABD population, and the TANF population. For example in a Cook collar county, we have the AABD but don't have the duals, or parents and children, so it is too soon to pursue the match.

IX. 2013 Meeting Dates

Dr. Jones reviewed the dates posted in the meeting notice which are on Tuesdays and are February 5, April 9, July 9 and October 8, 2013. Members present did not identify any conflicts with these dates.

X. Open to Subcommittee

Dr. Jones asked if there additional topics the committee wished to discuss at a future meeting.

- Dee Ann Ryan asked if the group could review the Department's long range vision for the different care coordination projects to determine what the best fit is for Illinois.

Mr. Parker responded that in the long term, all the models will be evaluated and HFS is definitely interested in comparing the different models. He stated that on the back end, on the quality measures, all the models will be evaluated on the quality metrics for everyone serving the adult disabled and elderly. As the Department learns, it may decide to favor a model or not, or just share lessons on models. HFS may see better outcomes but not know what caused them. We talked earlier about health assessments. Could we favor one? The answer today is no.

Director Hamos added that Illinois is doing managed care the hard way by looking for new models and innovations for more complex populations. Some states have taken an easier route with Medicaid by just dividing up the regions and picking a couple plans to work first with the easiest populations. Illinois is not doing the one size fits all approach but is interested in testing new models for more complex populations.

She added that in preparing for the town hall meeting and the roll-out of the second phase of the Integrated Care program, the sister agencies are looking at compiling and releasing "Health and Quality of Life" performance measures. The measures should be available before the town hall meeting.

In looking at data, HFS realized that what is collected are "process" measures; like how many people were contacted, or how many forms were filled out. The plan is to look at health and quality of life measures for seniors and persons with disabilities, and put those out for public review and feedback. Eventually HFS would ask all our MCEs to be responsible for the same set of health and quality of life measures.

- Dr. Jones suggested inviting DHS and DoA staff to discuss opportunities for HFS providers to best work with agencies that are being paid under DHS and where can there be collaborations.
- Dr. Jones suggested looking at the idea of provider overload that comes about when a provider is working with six or more care coordination entities and getting different requests for information from each. Can we set some common goals to address this?
- John Peller would like to discuss some uniform drug formularies for all the CCEs and MCOs.
- Phillipe Largent would at some point like to discuss payment reform.

Mr. Parker stated that in the context of MCOs that have more flexibility, this could include testing new payment models like paying hospitals in a different way, covering episodic care or bundled rates.

XI. Next Meeting

The next meeting is scheduled for February 5, 2013 at 10 a.m.

XII. Adjournment

The session was adjourned at 11:55 a.m.