ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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Memorandum

DATE: December 31, 2013

TO: Members of the Medicaid Advisory Committee

FROM: Julie Hamos
Director

RE: Medicaid Advisory Committee (MAC) Meeting

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The next meeting of the Medicaid Advisory Committee is scheduled for Friday, January 10, 2014. The meeting will be held via videoconference from 10 a.m. to 12 p.m. Those attending in Springfield will meet at 201 South Grand Avenue East, 3rd floor video-conference Room B. Those attending in Chicago will meet at 401 South Clinton, 1st floor video-conference room.

Attached please find the agenda, draft minutes and bios for both Susan Hayes Gordon and Dr. Pont. As part of the department's ongoing efforts to reduce administrative cost, copies of the material will not be available at the meeting. Participants should plan on bringing their own copies.

The material has also been posted to the Department's Web site at:
http://www.hfs.illinois.gov/mac/news/

If you have any questions, or need to be reached during the meeting, please call 217-782-2570.

MEDICAID ADVISORY COMMITTEE

401 S. Clinton
1st Floor Video Conference Room
Chicago, Illinois

and

201 South Grand Avenue East
3rd Floor Video-conference Room
Springfield, Illinois

January 10, 2014
10 a.m. - 12 p.m.

AGENDA

I. Call to Order

II. Introductions

III. Approval of November 7, 2013 Meeting Minutes

IV. Director's Report

V. Nominating Committee Report

VI. Subcommittee Report

  a. Access Subcommittee Report

  b. Long Term Care Subcommittee Report

  c. Public Education Subcommittee Report

  d. Care Coordination Subcommittee Report

VII. Quality Scores for ICP Plans

VIII. Open to Committee

IX. Adjournment

Susan Hayes Gordon is Chief Communications and External Affairs Officer at Ann & Robert H. Lurie Children's Hospital of Chicago. She serves as a member of the senior management team and as an advisor to the CEO and senior management on matters of public policy, government relations, community relations, media relations and communications in support of the advancement of the hospital mission and programs. Under her leadership, the medical center monitors and influences regulation and legislation and works to strengthen relationships with internal and external constituencies, fostering awareness and participation among them to enhance the health and well-being of all children and to preserve essential government funding. A Leadership Greater Chicago Fellow, Ms. Gordon has served on numerous policy committees with the Children's Hospital Association, the Illinois Hospital Association, the Ounce of Prevention Fund and the State of Illinois' Medicaid Advisory Committee. She is also a board member of the Greater North Michigan Avenue Association and has served as a board member of the Illinois Council Against Handgun Violence.

Dr. Eddie Pont is a community pediatrician in Chicago's western suburbs. He has been involved with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) since 1996, serving as its president from 2006 through 2008. He is currently the organization's government affairs chair. He also sits on the state's Medicaid Advisory Committee, where he currently serves as chair of its subcommittee on care coordination.

Dr. Pont lives in Oak Park with his wife and three children.

Report: Definition of Non-Normal Births
for MAC January 10, 2014

At the last MAC meeting in November 2013, we had presented as yet uncertified (by IDPH) IL Birth Rate data, available from IDPH Vital Records, based on a query run via HFS' Enterprise Data Warehouse on July 1. 2013. We were asked during the MAC meeting what constituted a non-normal birth outcome? The following explanation is provided by way of definition.

The non-normal/normal categories focus on the baby/birth and classify births into mutually exclusive groups. "Non-normal" births are inclusive of low birth weight (LBW), very low birth weight (VLBW), infant mortality (IM), and not-normal diagnosis related grouping (DRG), i.e., 985, 385, 986, 386, 987, 387, 388, 989, 389, or 390*. Infant mortality and non-normal DRGs are identified throughout the infant's first year of life. So, a baby classified as a normal DRG at birth who has a non-normal DRG during the first year of life is then re-classified as non-normal. Likewise, a birth with a normal DRG resulting in death during the first year of life is then re-classified as non-normal. So, the system recognizes the most abnormal condition, if present, during the first year of a baby's life and classifies that birth as normal or non-normal.

Normal births are classified as those with a normal DRG who do not meet the criteria for inclusion in Non-normal during the first year of life.

*DRG description of Non-normal Births:
385, 985=Neonate, Died or Transferred to another Acute Care Facility
386, 986= Extreme Immaturity or Respiratory Distress Syndrome, Neonate
387, 987=Prematurity with Major Problems
388=Prematurity without Major Problems
389, 989=Full Term Neonate with Major Problems
390= Neonate with Other Significant Problems

Footnote: The above classification does not consider the mother's condition before, during or after delivery or the method of delivery. Even if the mother died during her delivery due to some unfortunate complication and the baby survived normally, that would be a normal birth. Also, the normal and non-normal categories are not affected by the method of delivery: a c-section, a forceps delivery, a breach delivery or induction of labor alone would not change the baby's birth classification!

Respectfully Submitted by: Arvind K. Goyal, Medical Director, HFS

Report on Collection & Analysis of HFS' Reproductive Data by Race & Ethnicity
for MAC January 10, 2014

At the last MAC meeting in November 2013, we presented the HFS' Family Planning Policy. During discussion, we were asked to address a question on the Collection & Analysis of HFS' Reproductive Data by Race & Ethnicity at today's meeting.

1. Race and Ethnicity data, if available, can be useful in targeting services and interventions for improvements when disparities are identified
2. Race and Ethnicity information is not required for determination of eligibility or to receive services. We request it because numerous reports are created using the data we collect. Since there is no legal mandate to collect that information, we can only ask, but not require, that question be answered. Overlapping federal laws and regulations, including Civil Rights Act of 1964 and Social Security Act, require that this be an optional field. As an example, the IHW application section regarding race/ethnicity says "you do not have to tell us", and there is a box for unknown. At times, unknowns are as high as 50%. We have reasons to believe that intake workers may check that box, even without asking. Some would argue that incomplete, inconsistent and unreliable data may be worse than no data!
3. Many providers are similarly reluctant to ask their patients or share with us race and ethnicity related information in the absence of any such requirement.
4. IL Pregnancy Risk Assessment Monitoring System (PRAMS) 2009 data, the last year for which it is available, informs us that:

   i). African American women had higher percentage of unintended pregnancies compared to others

   ii). African American women were less likely to be aware of the benefits of folic acid in preventing birth defects when compared with others

   iii). Although there was an overall gradual decline in the percentage of reported smoking during pregnancy between 1998 and 2009, gaps remained; non-Hispanic women were more likely to smoke than Hispanic women; further, women whose deliveries were paid for by Medicaid were more likely to smoke than women whose deliveries were not paid for by Medicaid

   iv).Non-Hispanic women were more likely to report drinking when compared with Hispanic women; and, women whose deliveries were not paid for by Medicaid reported higher percentages of drinking during pregnancy when compared with women whose deliveries were paid for by Medicaid, and

   v). After the baby was born, Non-Hispanic women were more likely to report being diagnosed with depression when compared with Hispanic women; and, women whose deliveries were paid for by Medicaid were more likely to report being diagnosed with depression when compared with women whose deliveries were not paid for by Medicaid.
5. HFS' Perinatal Report 2012 indicates Illinois' infant mortality rate has decreased from 10.7 in 1990, to 7.2 in 2009. Although the infant mortality rate for African Americans has continued to decrease, the racial disparity in the infant mortality rate continues to be dramatic, with the African American rate almost two and a half times higher than the White rate (13.9 compared to 5.8, 2008).
6. We would appreciate your suggestions how we can improve collection of this valuable information given the limitations and constraints described above.

Respectfully Submitted by: Arvind K. Goyal, Medical Director, HFS

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AETNA BETTER HEALTH of ILLINOIS

Medicaid Advisory Council
Aetna Better Health Quality Performance Review
January 10, 2014

William Gerardi, MD
CMO
Aetna Better Health of Illinois

Ann Cahill
Vice President MedicalManagement
Illinicare

Quality Program Overview

- 50 quality metrics comprised of 22 Pay for Performance and 28 Quality Monitoring measures (8 were N/A for 1st year)
- Comprised of a combination of HEDIS, HEDIS-like (Hybrid) and State specific measures
- Measures include clinical preventive care, drug monitoring and adherence to therapy, access to care and utilization of services
- Baselines are established from FFS program for year 1
- Programs based on national standards
  - HEDIS – Health Effectiveness Data & Information Set
  - NCQA- National Committee for Quality Assurance

Quality – A Story of Progress

2012- First year of Integrated Care Program

- Results were mixed – some measures improved, some declined
- Primary focus on connecting with the members
    - Assessments
    - Services
- Many changes for members, providers and MCOs
- Data challenges

2013- Second year of Integrated Care Program

- Results look better – almost all measures improved, data still preliminary
- Primary focus expanded to the providers
- Better understanding of the population and unique challenges
- Better at scrubbing the data
- Lessons learned
    - PCP, facilities and community providers – working together helps maximize the impact and care (FQHCs, PCPs, large integrated delivery systems)

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Illinicare Year 1 Results

P4P

- Improved over baseline in 12 of 21 measures
- Achieved stretch target in 8 measures where improvement over baseline was shown
- 10 measures that qualified for year 1 measurement were HEDIS specific of which 6 improved in percentile ranking, 4 stayed the same
- Readmission and follow up after hospitalizations showed declines
- Utilization and medication adherence rates showed improvement

Quality Monitoring

- Improved over baseline in 13 measures, declined in 7 and 8 were NA for year 1
- Achieved stretch target in 12 of 13 measures where improvement over baseline was shown
- 11 measures that qualified for year 1 measurement were HEDIS specific – 9 improved in percentile ranking, 2 stayed the same
- Of 10 measures which declined, 4 were BH related, 1 was dental for DD population, 1 was for HbA1C for DD population and the other was cervical cancer screening

Aetna Better Health Year 1 Results

- P4P
- Improved over baseline in 20 of 21 measures (1 measure did not have enough continuous enrollment therefore not included)
- Achieved stretch target in 12 of the 20 measures where improvement over baseline was shown
- 10 measures that qualified for year 1 measurement were HEDIS defined of which 8 improved in percentile ranking, 2 stayed the same
- One element which declined was 30 day follow up after hospitalization for mental illness
- Quality Monitoring
- Results: 17 measures improved, 4 declined, and 7 were NA for year 1
- Reached stretch target in 13 of 17 measures where improvement over baseline was shown
- 11 measures that qualified for year 1 measurement were HEDIS specific – 8 improved in percentile ranking, 2 stayed the same and 1 fell
- Of 4 measures which declined, 2 were BH related, 1 was dental for DD population and the other was cervical cancer screening*

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2014 Focus on these areas will further improve our results

- Increasing BH capacity to more effectively drive quality
- Continue implementing innovative programs with community based organizations to impact health outcomes
- Reaching and engaging members is a critical success factor
- Utilizing contract models to better align reimbursement with quality performance is important
- Addressing confusion in the provider community when national practice guidelines differ from community practice standards for vulnerable populations
- Improving data management

Aetna Current and Potential Interventions (1)

What we are doing:

- Co-location of Case Managers
- On going monthly monitoring – see sample report
- Implemented physician pay for performance program
- Ramped up member outreach to address care gaps and provide education – utilize member mailers, phone calls and web resources
- Waive authorization requirements for Rule 132 services
- ICT follows up with members who had potential ED visits on daily basis
- Utilize disease management resources to provide follow up coaching on therapy regimens
- Implemented drug adherence programs and education through PBM
- 100% follow up post discharge after hospitalization for mental illness

Aetna Current and Potential Interventions (2)

What we will be doing:

- Increase collaboration with community based organizations in care coordination
- Provide more services in home –
  - mobile dentistry;
  - home physicians;
  - sending BH providers to see members in their environment
- Leverage telemedicine – especially to improve BH capacity
- Refine physician P4P program to better align with State and Plan quality goals and to improve performance
- Rolling out new physician reimbursement models to impact quality results
- Evaluate vendor relationships to improve results – i.e. Collaborate with PBM on medication therapy management initiatives

Illinicare Interventions

- We must spend time and resources to remove barriers and encourage members' healthy behaviors
  - Outreach calls to members to educate about quality measures
  - Home visits by physicians to draw labs (i.e. Cholesterol testing)
  - Arrange for prescriptions to be filled, then picked up at pharmacy and delivered to home
- Encourage Providers/PCPs to connect with their members, provide access to and manage clinical services and encourage healthy behaviors
  - Outreach calls to providers to educate about quality measures
  - Identify provider barriers to meeting quality measures
    - Eg - review and elimination of step therapy for certain IM antipsychotics for members in a pharmaceutical study
  - Provider incentives to close quality gaps
- Help Members to accept or buy in to services/healthy behaviors
  - Member education regarding the importance of certain tests, taking their medicines, the need for immunizations
  - Helping members identify where to get their medications, tests, immunizations (i.e. breast cancer screenings)
- Data Management
  - Work with quality software to ensure the specifications are entered correctly – the right members are identified and the right codes are pulled
  - Identify when members access care that isn't captured through our systems (i.e. DD dental care)

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Conclusion

- For first year of a program, many positive developments – improvement over baseline in over half of the measures
- Focused on improvement in all measures, but special emphasis on those metrics where we saw a decline
- Both health plans utilize continuous monitoring of quality results and adjust resources as necessary based on what we are seeing
- Preliminary 2013 results shows further improvement
- Plans are actively working with HFS to implement a program to invest in Community Mental Health Centers to develop capacity in ACT and CST programs
- Maintain our commitment to promoting the highest quality outcomes of the program

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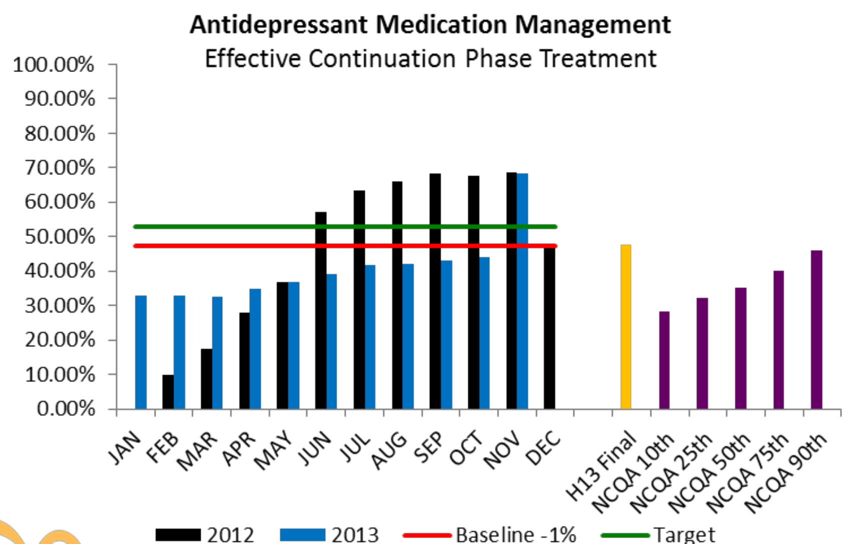
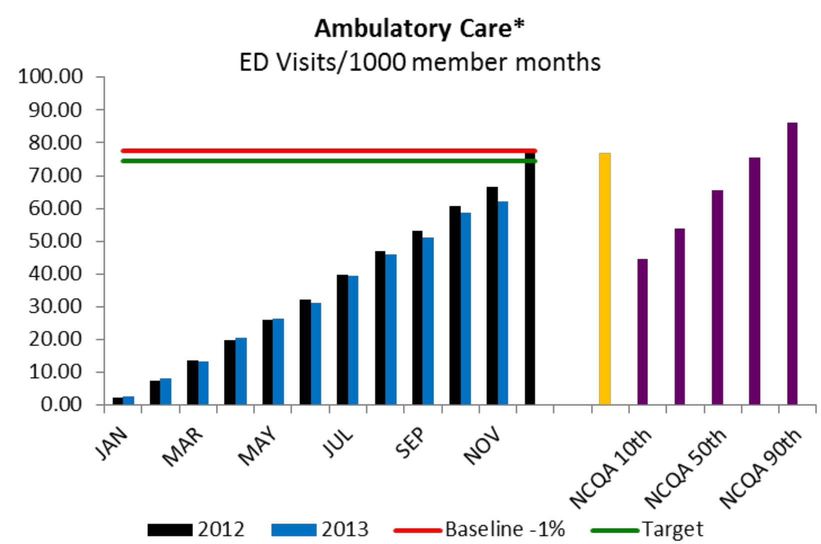
Aetna Sample Monitoring Report

IL P4P Rates for MY 2013: Current to 11-30-13																		
QSI ID	HFS #	HFS ID	Tech Spec	P4P Measure	Outreach Group	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	minus 1%
APE13IL	1.3	APE	State	**Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit** *(Does not include mental health or chemical dependency services)*	Time Limited F/U	0.00%	30.91%	35.35%	38.29%	39.75%	40.57%	39.15%	39.38%	39.78%	40.45%	40.88%		40.51%
API13IL	1.5	API	State	**Provider within 14 Days of Inpatient Discharge** *(Does not include mental health or chemical dependency services; Does not include hospitalizations for OB deliveries)*	Time Limited F/U	0.00%	40.55%	45.76%	48.18%	50.03%	49.95%	48.63%	46.28%	47.75%	48.01%	49.76%		53.56%
AMB13	1.2	AMB	HEDIS	**Ambulatory Care [Lower # is better]** - **<u>ED Visits/1000 member months</u>** - ED Visits – DD Only *(Does not include mental health or chemical dependency services)*	Utilization Management	2.75	8.17	13.53	20.55	26.43	31.24	39.33	45.88	50.94	58.56	61.94		77.70
AMM13	8.1.1	AMM	HEDIS	**Antidepressant Medication Management** - Effective Acute Phase Treatment	Time Limited F/U Rx	54.19%	55.33%	54.35%	57.39%	55.74%	57.79%	57.92%	57.44%	57.44%	57.68%	79.34%		54.89%
AMM13	8.1.2	AMM	HEDIS	**Antidepressant Medication Management** - Effective Continuation Phase Treatment	Time Limited F/U Rx	32.96%	32.99%	32.56%	34.78%	36.89%	33.95%	41.67%	42.15%	42.98%	43.98%	68.18%		47.19%





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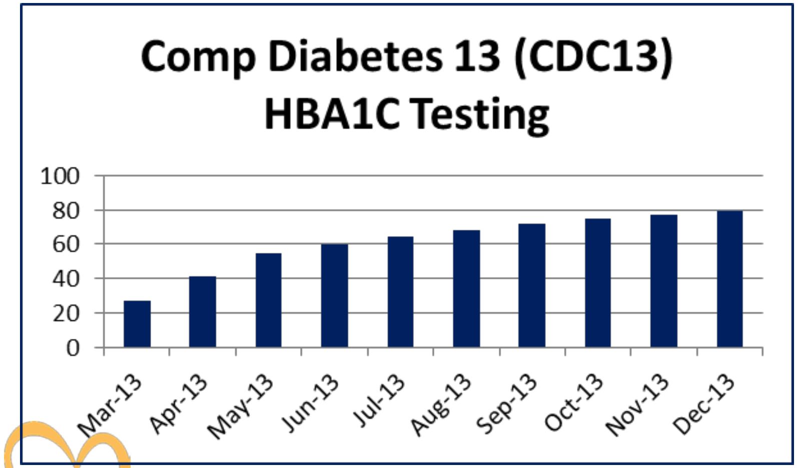
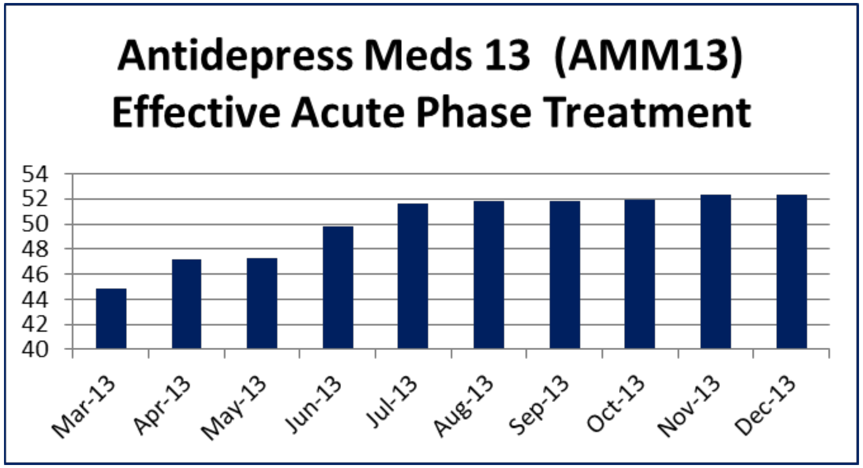
Illinicare Sample Monitoring Report

HEDIS 2014

Population	Measure	Submeasure	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
ALL	Comp Diabetes 13 (CDC13)	HBA1C Testing	26.97	41.41	54.59	59.72	64.44	68.34	72.11	74.78	77.46	79.77
ALL	Cholesterol Mgmt 13 (CMC13)	LDL-C Screening	28.25	41.45	53.76	57.45	63.47	66.47	69.13	71.89	75.05	77.95
ALL	Persist B Blocker 13 (PBH13)	Persist B Blocker	67.86	72.41	87.88	81.4	83.33	87.76	90.74	96.3	96.43	96.49
ALL	Antidepress Meds 13 (AMM13)	Effective Acute Phase Treatment	44.9	47.13	47.25	49.82	51.6	51.79	51.8	51.97	52.31	52.31
ALL	Pharm Mgmt COPD 13 (PCE13)	Systemic Corticosteroids	79.45	81.9	81.66	80.83	80.63	75.77	75.0	76.38	76.73	75.06





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