Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
February 5, 2013

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

Members Present
Edward Pont, Chairperson, M.D., IL Chapter AAP
Kelly Carter, IPHCA
Kathy Chan, IMCHC
Art Jones, M.D., LCHC & HMA

HFS Staff
Julie Hamos
James Parker
Arvind Goyal
Debra Clemons
Lauren Tomko
Andrea Bennett
James Monk

Interested Parties
Salim Al Nurridin, HCI
Amanda Attaway, IMSA
Lori Benso, Health Alliance
Karen Brach, BCBSIL
John Bullard, Amgen
Shannon Butler, Humana
Geri Clark, DSCC
Matthew Collins, HealthSpring
Marsha Conroy, Aunt Martha's
Mike Cotton, Meridian Health Plan
Tom Erickson, BMS
Opella Ernest, BCBSIL
Gary Fitzgerald, Harmony-Wellcare
Eric Foster, IADDA
Michael Freda, Precedence CCE
Jan Gambach, MHCCI
Bill Gerardi, Aetna
Donna Gerber, BCBSIL
Donna Ginther, HCCI
Laurie Good, MHP
Susan Gordon, Lurie Children's Hospital
Danise Habun, CCA
Marvin Hazelwood, Consultant
Thomas Jerkovitz, DSCC
Jeff Joy, IlliniCare
M. G. Katz, HealthSpring
Vijay Kotte, Meridian HP
Judy King
Diana Knaeb, Heritage BHC
Kathleen Kinsella, HCI

Members Absent
Ann Clancy, CCOHF
Vince Keenan, IAFP
Margaret Kirkegaard, M.D., IHC, AHS
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
Janet Stover, IARF

Interested Parties Continued
Christine Kourouklis, HealthSpring
Keith Kudla, FHN
Marissa Kirby, IARF
Mike Lafond, Abbott
Marvin Lindsey, CBHA
Sinead Madigan, Health Alliance
Randall Mark, Cook County Health Services
Genevieve Martin, Humana
Grace Martos, Molina Healthcare
Bill McAndrew, IHA
Kevin McFadden, Astra Zeneca
Jim McNamara, ViiV Healthcare
Mona Martin, PHRMA
Susan Melczer, MCHC
Karen Moredock, DCFS
Michael Murphy, Meridian
Sanjoy Musunuri, Aetna
Jim Nicholas, Gateway Foundation
Heather O'Donnell, Thresholds
Tim O'Rourke, Humana
John Peller, Aids Foundation of IL
Louanner Peters, HCI
Melissa Picciola, Equip for Equality
Jennie Pinkwater, ICAAP
Jay Powell, AmeriHealth Mercy
Sam Robinson, Canary Telehealth
Julie Ross, Abbott
Ken Ryan, ISMS
Amy Sagen, U of IL Health system
Bernie Stetz, Molina Healthcare
Cynthia Waldeck, Heartland Alliance
Kathy Waligora, IMCHC
Erika Wicks, HMA
Tom Wilson, Access Living
Brenda Wolf, La Rabida Children's Hospital

I. Call to Order

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Dr. Edward Pont 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. Review of October 2, 2012 and January 8, 2013 meeting 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 or January minutes.

IV. MMAI and CCE/MCCN Presentations

Presenters were either in Chicago or Springfield. Because of the number of presenters and time constraints, Dr. Pont asked that questions be held until after all presentations. He advised that meeting participants could also submit questions to HFS to share with presenters to ensure all persons present had an opportunity to ask questions and provide comments.

To varying degrees, presenters described their geographic region, demographics relevant to the SPD population, major partners, clinical philosophy, innovations, communication and reports technology, data analytics and plans for provider engagement. Available Presentation handouts are posted at: http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommisions/MAC/cc/Pages/planpresentations.aspx
The CCE and MCCN entities under the Innovations project presented first, followed by the Medicare Medicaid Alignment Initiative (MMAI) representatives. The presentations are summarized below.

Healthcare Consortium of Illinois. Presenters were Salim Al Nurridin, CEO and Louanner Peters, Executive Director. HCI has been involved with care coordination for the last 20 years. We have had the opportunity to work with DCFS in the Healthworks program, which is used in Illinois and a model for other states. It is an integrated program for children taken into state custody that need immediate comprehensive health screenings. This has allowed HCI to develop a network of providers, work in an integrated health system and develop integrated health plans. The local network is supported with community health workers as part of the care team. Healthcare delivery happens in a neighborhood based way.

HCI-CCE is based on an inter-disciplinary approach to develop a care plan that will require 1 to 4 face-to-face home visits by a case manager who will lead in the coordination of care. Based on the acuity, the case manager may be an RN or licensed social worker or navigator. In some instances HCI will use telemedicine for persons with higher acuity and needing more monitoring. HCI looks to reduce the episodic crisis that can lead to service in the emergency room or in extended hospital stays. HCI plans to work with Roseland, St Bernard, South Shore and University of Chicago hospitals.

Precedence Care Coordination Entity LLC (MCCN plan) Michael Freda, CEO presented. This project tests a model organized through a major hospital system, featuring integration of primary and behavioral care with community health agencies in 3 health home hubs covering 9 counties in north, west, and central Illinois. The LaSalle hub providers include North Central Behavioral Health, OSF St. Elizabeth's Hospital, and a primary care practice. Sinnissippi Centers, KSB medical group and hospital and local primary care cover the Dixon hub. The Robert Young Center, Trinity Medical Center, Riverside, and Community Health Care cover the Quad Cities hub.

The target population is about 2,800 adults with substance abuse issues and at least one other medical disorder like diabetes or COPD. Direct service is planned for about 1,500 persons. Care coordination includes assisting in the transition from one level of care to another, patient and family support and patient self-management. We will link disparate providers using health information technology and getting analytics out in real time for enhanced patient care. A key measure is quality of life for the individual.

The innovation is based on a project over the last 3 years with the severely mentally ill in partnership with community health care where we have established behavioral health homes. The project staff are co-located in both the health and mental health facilities. The work included education for PCPs to better manage that population with us. The outcomes for about 400 patients show a decrease in medical hospitalizations by 58% and substantial savings. Positive change in patient quality of life surveys has shown improvement from 38 to 88%. We desire the best outcome for every patient, every time.

Aetna Better Health Sanjoy Musunuri presented with William Gerardi, Chief Medical Officer. Aetna has 20 years of Medicaid experience and 46 years of Medicare experience. There are 18,000 members in the Integrated Care program in Illinois. There are about 11,000 Medicare Advantage members in the greater Chicago service area. Aetna will serve about 120,000 persons in the MMAI program in Illinois.

Our philosophy is that integration comes to fruition through a single point of contact for the member spanning all their needs in all of the settings. It offers an easy to navigate system for both providers and members. Providers will be both Medicaid and Medicare providers. The vision is health wellness and improvement in health status. Care plans will encourage self-direction while providing care team support.

The structural concept of care is on the basis of "one". This means one ID card, one provider bill, one provider payment, one care team with one care coordinator for an individual member. The member's multi-disciplinary care team is responsible for coordination of all care in all settings and with all provider types.

Aetna is working with providers to move from a volume-based relationship to a value-based relationship by offering flexible tools and methodologies like pay-for-performance programs, PCMH programs, shared savings or risk based relationships. Ultimately it will be to an ACO type concept, if it is the right fit for the provider.

Health Alliance Lorie Bledsoe, Senior VP/General Counsel was the presenter with Sinead Madigan, Director of Government Relations. Based in Urbana, Illinois, Health Alliance has been in existence for 32 years serving about 300,000 lives and about 16,000 members in its Medicare Advantage program. This 4.5 star rated program has been around for 16 years and has an NQCA rating of excellent. The plan will cover central Illinois with partners in Springfield and Peoria. The focus is on quality care for patients with the best possible outcome. The care model is similar to Aetna.

Healthcare Service Company (Blue Cross/Blue Shield) Karen Brach, VP of Medicaid Operations, was the presenter. She was with Dr. Opella Ernest, Chief Medical Officer, and Donna Gerber, VP of Strategy and Community Investments. Healthcare Service Company is a locally based 77-year-old company. In Illinois, HSC has 3.5 million members and 16 locations employing over 8,000 people. HSC builds on established relations with providers and will partner with residents, providers and CBOs.

The model is member and care giver centric. The plan will include a feedback mechanism in collaboration with advisory councils to ensure that member and providers have a voice, and that programs are compliant and culturally sensitive. There will be strong member and consumer protections built into the program and the innovative member-centric care delivery model. This is a key to a successful program for all parties. There will be wrap-around support for the health plan with a dedicated multi-disciplinary team that includes the member and caregiver or responsible party, the PCP and medical home, and dedicated care coordination staff using a social service and a clinical model that is both bio-social and psycho-social.

We will add an independent living LTSS coordinator helping people return to or remain in the community. Ad hoc members on our multi-disciplinary group include the chief medical officer and pharmacy staff to

build an individual care plan for the right setting and best outcomes. We plan to launch innovative provider relationships like pay-for-value and shared savings program. These are ways to engage our providers and members together to improve quality outcomes.

HealthSpring of Tennessee, Inc. Mathew Collins, VP Regional Operations and Dr. Marshal Katz, Senior Medical Director made the presentation to the MAC about HealthSpring, but declined to have its materials posted to the website.

Mr. Collins advised that he would highlight some things that make them a little different. HealthSpring is a leading Medicare Advantage program. It started as a provider entity and is provider focused. HealthSpring is in 13 states with over 1 million members. Last February, the company was acquired by CIGNA. They are their "seniors" segment operating arm. HealthSpring has been in Rosemont, Illinois since 2004, and are now looking to add a location in Chicago to be more accessible for jobs, members, and public transportation. They expect to go from 50 to 200 plus employees. Currently, about 20 - 25% of members are dual-eligible.

A main focus is to transform the experience by taking the opportunity to deal with partners, members and employees in a new way. We don't think the healthcare system is broken but working exactly as designed. It is producing a high number of procedures without a premium on value. We are working to transform that to something that makes sense. HealthSpring has a depth of experience in risk coding and in coordinated care longitudinally with the PCP driving and caring for that member long term.

The HealthSpring clinical model has two parallel roads with the end point being better quality care for members. One road is working closely and effectively with physicians in small groups, around their hospitals and specialties, helping them in any way we can. We encourage patients to see their PCP and go for routine examinations. We help by providing transportation, calling members and making appointments. We promote preventative care services like colonoscopies, mammograms, visions tests, and blood tests.

The other road provides members with all kinds of programs to make sure they are getting good care. These include face to face and telephonic case management programs, onsite nurses working with attending physicians, discharge planners, social workers, and case managers to make sure that patients get the services need once they get home. A favorite program is "HealthSpring at Home." Staff can include nurses, social workers, behavioral health specialists, or respiration therapists that go out to the patient's home when one of the team members has heard something or is concerned about something for the patient.

Humana Health Plan Tim O'Rourke, President of the Great Lakes region was the presenter. Humana has a 50 year history of supporting both public and private payers. It has 27 years experience as a plan contractor under the Medicare program and 17 years experience in Medicaid participation. It is one of America's largest Medicare Advantage contractors and the largest in Illinois with 180,000 members, of which 25,000 are dual-eligible beneficiaries. Humana has formed partnerships with many key provider organizations and has initiatives encompassing comprehensive health centers that focus on low-income seniors in medically underserved areas and on complex medical case management of the medically fragile.

Humana has an integrated suite of population health management and care coordination programs to address the entire continuum of health needs. It offers team-based, multi-disciplinary services that wrap-around and support existing PCPs and medical homes. The model of care includes a "high touch" component to compliment Humana's information technology systems and office based resources. It will place hundreds of care managers to engage Illinois dual-eligibles to lower costs and improve outcomes.

Humana uses a robust, proactive data analytic and predictive modeling process to channel members to the appropriate level of care at the right time to make the maximum impact possible. To address the unique and intensive need of this population, we will bring our experience serving the LTC eligible population and specifically providing home and community based waiver services to eligible individuals. We will use a successful model for managing care and driving successful outcomes for members in institutional settings.

Humana's focus on providing the best possible quality of care is demonstrated in our dual-eligible special needs plan model of care which has received a three-year CMS approval based on NCQA scores in the highest achievable range. We will bring this expertise of improving quality to this dual-eligible population.

IlliniCare Health Plan Ann Cahill, VP for Medical Management, presented from Springfield. Jeff Joy, the new CEO introduced himself in Chicago. He shared that he previously ran a large Medicaid plan for John Hopkins. IlliniCare is one of 18 health plans under the Centene Corporation serving over 2.7 million Medicaid beneficiaries across the country. IlliniCare was established in 2011, when Centene was awarded the Integrated Care Program contract, and has worked with the SPD population in the Chicago area since then. Their office is located in Westmont, Illinois, and has over 150 employees and growing. It currently serves 18,000 members in Illinois with a network of over 2,000 PCPs, over 5,000 specialists and 63 hospitals.

The care coordination model is an integrated, multi-disciplinary care team with both nurse and behavioral care coordinators to work with members that have acute and behavioral medical needs. We have program specialists that are usually social workers that work with moderate risk members, and non-clinical support workers that support the team and provide preventative education to our low-risk members. The plan has recently added an LTSS coordinator which works with members receiving Medicaid waiver services.

IlliniCare has a working relationship with HFS, DRS, and DOA, and has established tools and means of exchanging data confidentially with HFS. We anticipate keeping the same care coordination model that is in place right now and building bridges with those non-Medicaid services and community stakeholders that might already be serving this population.

Meridian Health Plan of IL Vijay Kotte, President/COO of Medicare Operations was the presenter. Michael Cotton President/COO of Illinois and Laurie Good, VP of Utilization Management joined him. Meridian has been serving the Medicaid population in the Quad Cities since 2008 and is now serving 20 counties for the TANF population. It is a physician owned and directed company committed to providing high quality service. We describe ourselves as physician directed, member centered, and quality driven. Meridian is a care coordination company that happens to be an insurance company. It is a top goal to continually lead the nation in quality scores as done in the Michigan market with 300,000 members, and in Illinois with the TANF population. We will bring that same effort into the Medicare Medicaid Alignment Initiative.

What make our care model successful are the values of the organization, our knowledge, tools and effort. We understand that effort of getting that multi-disciplinary, inter-disciplinary team together is to identify the unique individualized care plan for the beneficiary, be it the physical, behavioral or social needs. The key is having the right services delivered at the right time.

Meridian has developed this proprietary data system over the last 15 to 16 years, specifically around having one system that integrates all data sources within our organizations. It is where all the provider data, claims and initial healthcare risk information is collected. The information integrates with our portal and our reporting systems so you can see everything that is happening for a member there. Our providers and care coordinators will have that information available to be able to act. If a member is admitted into a hospital, our partner hospitals will be able to communicate with our care coordinators to develop a

discharge plan and transition care from the acute facility directly back into the community or into a skilled nursing facility.
When it comes to effort, we augment with our community health outreach workers. They're the "arms and legs" to our care coordinators. Members can be hard to find so we have staff hired from those communities to gain member trust to help change behaviors, improve outcomes and increase independence.

Molina Healthcare of IL Bernadine Stetz, VP of Healthcare Services, presented. Grace Martos, Director of Healthcare Services was with her. Although new to Illinois, Molina has 33 years experience working with the Medicaid population. The plan was founded by emergency room physician, Dr. C. David Molina who noticed that patients were coming to the ER for primary care. He founded a clinic for those in need of care but unable to afford it. Today Molina's business touches 4.3 million Medicaid clients in 16 states. We operate 10 health plans in 10 states serving 1.7 million members, and we are also the fiscal intermediary in 5 other states. We have won dual-eligible awards in California and Ohio. All plans are NCQA accredited.

Our model of care is based on the Coleman model which has similar components as do the other plans. There is a health risk assessment, risk stratification of the member population and a care coordinator working with the member. While a lot of focus has been on institutionalization, we need to focus more on keeping members in the community. Two positions most beneficial to our model of care are the transitions coordinator and the community connector. The transitions coordinator assists members being discharged from the hospital to plan their return back to the home with 30-days follow-up by the coordinator to ensure the patient has the right medication and safety measures to prevent readmissions. Community Connectors are members of the community that understand the culture and work with our members and the community resources. They need some behavioral health expertise to assist members with services and interventions.

We are part of the Case Coordination Units Alliance in Illinois with organizations that are out in the community and working successfully with a lot of our membership. Another successful organization that we are working with is the Illinois Association for Rehabilitation Facilities and their community mental health trade association that will help us connect to community mental health centers in central Illinois. We encourage our colleagues to work with those agencies that are already successful in serving the dual-eligibles. We are passionate about our model of care. Our plan is to keep this population as healthy as possible and keep them in the community where they really want to be.

V. Open to Committee

Dr. Pont thanked the plan representatives for taking the time to come out and providing excellent presentations and letting participants know who the plans are, what their philosophies are and what plans each hope to bring to the table as we go forward. At this point, the meeting was opened for questions to the health plan representatives.

Q: Dr. Pont noted that Mr. Freda had pointed out decreased utilization of the ER and hospital. **He asked if that decreased utilization was in the benefit of the patient.** He asked plan representatives if there was utilization numbers that they may want to discuss and if some of the utilization numbers could be put in perspective. He was interested in 7 day readmission, 30 day readmission, and primary care utilization. For example if ER and hospital readmissions go down and primary care utilization goes up this is a positive.

A1: Mr. Collins responded that the plans look at all the same variables including the ones described. The HealthSpring approach has been to provide increased access to the Primary Care Physician (PCP). The process starts with the member having a comprehensive physical exam. It serves the HCC coding purpose and also in building the relationship between patient and PCP. It allows the PCP and patient to establish when it is appropriate to contact the PCP and when it is appropriate to seek additional medical care.

HealthSpring has seen, in their gauged units, a significant difference, and in the range of a 20 to 30% decrease in ER utilization and in hospital admissions. The key is to provide increased access to the PCP.

A2: Mr. Kotte stated that from the Meridian perspective, there is an emphasis on the care coordination effort. He noted that the question is a tricky one in the way you determine the denominators in calculating improvement. If it is not a longitudinal study, you are looking at population based statistics of an overall aggregate population that may not be reflective of the exact same propensity to be admitted into the facility. Meridian has used a predictive model to look at the population for care coordination that it believes to be at high risk for an admission and tries to track from the standpoint of which ones we can avoid getting into that catastrophic state. He would correlate a longitudinal type of a study saying that here is the historical experience and we are now using that to predict what the future propensity for an admission might be and how we can avoid that. You need enough numbers over a longer period of time to test that. We have set some high level figures of being able to avoid readmissions had there not been care coordination at 10 to 15%. The total cost of the beneficiary is below what you would expect if they had not engaged in care coordination. This could be interpreted as increased primary service that avoided the catastrophic event.

Dr. Pont stated that as a consumer faced with a choice of 5 to 6 plans in area, he would want to go with the plan that has a history of benefiting the patient with increased primary care access and lower catastrophic events for those most at risk.

A3: William Gerardi, Chief Medical Officer at Aetna Better Health stated that one of Aetna's goals is to increase access and remove barriers to care. One step they are taking is to remove all pre-certification requirements for behavioral health services regardless of if the provider is in network. If you look at the first year of experience across the Integrate Care program, Aetna has seen a significant reduction in ED visits compared to the baseline population prior to the program launch. There has been a significant decrease in readmission rates. Aetna is still evaluating the PCP visit question. There are some challenges with the baseline percentages but he believes the PCP visits are up from that earlier group.

A4: Ms. Peters of the Healthcare Consortium of Illinois stated that the CCE model brings something to this even though it is not a risk entity. Regarding base quality measurements set by the state; our team recognized that to get to the desired outcomes we would need to increase quality measures like contact with the PCP. In the Medicaid population where someone may have co-morbidities like having COPD, diabetes and obesity, we want the best care model on the preventative side so the client doesn't end up in the hospital.

A5: Mr. Freda stated that Precedence CCE has data that tracks the ED visits for both psych and for medical and, hospitalization data for psych and medical. On the psychiatric side, we have always had a low ED penetration for crisis and a low rate of hospitalization. On the medical side, we have seen a decrease in the ED visits as well as the admissions and pre-admissions. We discovered initially that with the FQHC clinic located in their facility, the providers were sending individuals to the ED when they felt they were getting more individuals than what they may have wanted to handle. The relationship over this period of time has been to help them understand this inappropriate ED use. We have decreased sending patients to the ED and also used a behavioral best practice for crisis planning with these individuals to meet the patient needs. It is a "tagged" population as we know these individuals.

Q: Tom Wilson of Access Living asked **how entities are addressing the special needs of the disabled.** He stated that as a member of the disability community, we know that many hospitals and clinics don't have accessible equipment like scales that take wheel chairs. The deaf community is often left without interpreters for their medical visits. We value peer services and think that people with disabilities often know most about barriers and problems that persons with disabilities face. Peers may find solutions and

ideas that may not be coming from the professional community. Durable medical equipment means a lot to people with disabilities and mobility is really important to their independence. With mental health services, many people receive the drugs but not the counseling that would go with it.

A1: One provider commented that we are working on access issues but not yet where we want to be. We are working with the United Spinal Association so that providers may get certification to provide easier access to our administrative spaces and provider offices. The biggest determinant we have seen for increasing utilization is physician engagement. We work with physicians to look at their entire population to recognize who has special needs or chronic conditions to get them to understand what that means.

A2: Ms. Brach from BCBSIL stated that analytics and reporting are important when addressing the special needs of persons with disabilities. She recommended for a plan to be successful there is a need for a headline report or data that tells you where there are gaps in care. The gap may simply be that a service is not physically accessible. An important member of their inter-disciplinary team is the independent living transitions coordinator or LTSS coordinator. Their key role is to identify barriers and gaps. That person will be instrumental in the help plan and wrap-around team in addressing those barriers for members with disabilities with access issues.

Q: Dr. Jones asked both the Department and health plan representatives **how collaboration among entities can be facilitated for care management with aligned incentives.** The assumption behind MMAI and bringing the SPD population into managed care is that there is fragmentation of care and therefore low value care. If we can reduce fragmentation, we can improve the value. Looking at fragmentation from a payer standpoint, Cook County has 6 MMAI plans, 2 additional plans serving the Medicaid population, potentially 3 CCEs, Medical Home Network, and County Care for a total of 13 different providers. Each plan will have their centralized care management, outcome measures, and reports. We want to move toward a system of accountable payment but how can this be done if the patients are distributed among 13 entities?

A1: James Parker, Deputy Director of Operations responded that HFS is trying to make sure that we measure all these programs equally. All the quality measures are uniform across the plans and models. This will allow HFS to compare them. There is an attempt to have the plans coordinate on some administrative functions to make it easier for providers to operate without six different standards for billing, utilization review or contracting. HFS is encouraging the plans to work together. The state is pursuing a grant to help the Department make sure from a high level that we are getting all of the payers and incenting the same things.

A2: HFS Director, Julie Hamos added that one of the things that Mr. Parker talked about was the quality measures. Some of these quality measures and pay-for-performance measures in the contracts are now called something worked out with our sister agencies, Health and Quality of Life performance measures and are posted on the website at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/ICPHQLPM.pdf These are available for comment right now. These are measures that the Department will be assessing either through claims data or through surveys. HFS would like your feedback on these measures. When finalized, these measures will be the benchmark for all the plans.

It is also true that we have a very large Medicaid population in Illinois. How to move from fee-for-service to coordinated care is something the Department thought long and hard about. Illinois has a very diverse population and because of this the Department wanted to test some different models. The issue of collaboration is something that the Department will need to monitor and think about.

A3: Mr. Al Nurridin noted that it is not only what the state would do but also what the different entities would do to promote collaboration and have a positive impact on the people served. Whether we call it the

community connector or the community health worker or outreach, these are models that need some additional codification to ensure consistency. HFS needs to do more with certification and training because of the community health worker movement. He advised that HCI chairs the Illinois Community Health Network and encouraged entities to join the network to have an effect on policy and training.

A4: Ms. Brach stated that she is a member of the Medicaid Health Plan Association as are some other entities. One of their key objectives is, where applicable, and where they can, to take standard approaches to working together and collaborating. A goal for HFS, BCBSIL, and other entities is to work together and take standard approaches where possible to best serve clients.

Q: How long will MCO enrollees be allowed to stay on their current drug regimens before switching to the plan formulary and is the formulary similar to the Medicare Part D formulary?

A1: Ms. Cahill of IlliniCare stated that there is a 180 day transition of care. There is also access through a prior approval. The formulary must include the same drug classes as Medicare Part D.

A2: Aetna staff stated that they currently have a prior approval process in place and it will continue under MMAI. This is for medications that are not on the plan formulary. He was not sure if the transition period was 90 or 180 days. The formulary must include the same drug classes as Medicare Part D.

Dr. Judy King asked several questions.
Q1: With respect to data analytics **what kind of demographic factors will you look at to identify health disparities?** For example women with disabilities are less likely to have PAP smears.

Q2: In looking at influenza and administering the flu vaccine **at two hospitals for one MCO, the rates of administering the vaccines were very low. How will that be addressed with those entities?**

Q3: How do you coordinate immunizations for adults?

A: Ms. Peters of HCI responded that it is necessary to start a relationship with the patient early on and establishing trust. From there we can discuss looking for a better way to access services. We can also call the provider and discuss needed preventive services that are not being received.

A: Another plan representative noted that the provider community has resources today that are working together to try to initiate immunizations and other preventive measures. Sometime the provider doesn't have visibility into all the other barriers that may exist for the member. As many of us have described in our care models, we are going to support that with folks from our side of the house that can see things that the provider can't. If we need to bring an immunization to a member, we will do that. We will meet with the member in their home and work on a plan that best meets their needs. We will then use our data to determine where problems still exist and use the metrics to work with the medical home.

A: Ms. Good added that these are perfect questions and it segues into Meridian's care coordination program which has a history of high HEDIS scores that include measurements for PAP smears, breast exams and immunizations. Meridian can draw a real fine line between implementation of their community health outreach work which began a year ago where staff is going out into the field when we can't reach the member telephonically and identify those gaps in care. There has been a significant increase in our HEDIS scores based on our community outreach program.

A: Another plan representative stated that all the entities are looking on a patient level and physician level to identify those gaps and using quality measures like HEDIS and STARS and all the other various metrics. It is an ongoing effort to review the analytics and apply them to the patient setting.

Dr. Pont shared that the MAC has talked about developing some kind of dashboard that consumers could get to with quantitative data on things like HEDIS, number of PAP smears and immunizations that will help not only the MMAI population but the approximate 1.4 million Medicaid clients that will be moved into manage care. Consumers will need to know who the good performers are so they can make an informed choice. A key issue is to ensure continuity of care.

Donna Ginther from HCCI, an organization that works with long-term care facilities, stated that she believed that all the plan representatives have tremendous experience in terms of primary care. She believed that there are some great programs for following people in the community and making sure they receive their services. She stated that we have many frail, elderly people who receive Medicaid and reside in nursing homes which may not be able to transition into the community and may not have family to support them. It would be great to believe that they could look at all the data and decide which plan to go with but they are not necessarily going to have that capability. She encourages the plan representatives to give some thought on how to make this work for this population.

VI. Next Meeting

The next meeting is scheduled for Tuesday, April 9, 2013 from 10 a.m. to 12 p.m.

VII. Adjournment

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