

**Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
June 20, 2012**

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

Members Present

Edward Pont, committee chair, M.D., IL Chapter AAP
Diana Knaebe, Heritage BHC
Kathy Chan, IMCHC

HFS Staff

Julie Hamos
Robyn Nardone
Michelle Maher
Greg Wilson
Pam Bunch
Andrea Bennett
James Monk

Interested Parties

Amanda Attaway, ISMS
Mary Ellen Baker, MedImmune
Marlene Blackwell, Conceptus
Hillary Bray, Access
Debbie Broadfield, IADDA
Chris Burnett, IARF
Carrie Chapman, LAF
Lea Cizek, Addus Healthcare
Geri Clark, DSCC
Sue Clark, Molina Healthcare
Cathy Cumpston, DHS/DMH
Kara Curtis, HCSC/BCBS of IL
Deila Davis, Access
Andrew Fairgrieve, HMA
Neil Flynn, Flynn Law
Jill Fraggos, Lurie Children's hospital
Susan Gaines, IPHCA
Katie Galle, Meridian Health Plan
Susan Greene, SGA
Michael Groban, M.D. WellCare
Barb Haller, IHA
Barbara Hay, FHN
Justin Hayford, AIDS LCC
Marvin Hazelwood, Consultant
Brian Hedinger, Jazz Pharmaceuticals
Nadeen Israel, Heartland Alliance
Nicole Kazee, U of I Health System

I. Call to Order

Dr. Pont called the meeting to order at 10:00 a.m.

Members Absent

Kelly Carter, IPHCA
Ann Clancy, CCOHF
Art Jones, M.D., LCHC & HMA
Vince Keenan, IAFP
Jerry Kruse, M.D., M.S.H.P., SIU SOM
Indru Punwani, D.D.S., M.S.D., Dept of Pediatric
Dentistry
Margaret Kirkegaard, M.D., IHC, AHS
Mike O'Donnell, ECLAAA, Inc.
Janet Stover, IARF

Presenters via conference call

Jamie Calabrese, M.D., Gateway Health Plan
Kyle Fisher, Penn. Health Law Project

Interested Parties Continued

Judy King, M.D.
Azmina Lakhani, SGA
Derek Lanier, Meridian Health Plan
Phillip Largent, LGS
Grace Martes, Molina Health
Mona Martini
Kevin Mc Fadden, Astra Zeneca
Susan Melczer, MCHC
Diane Montanez, Alivio Medical Center
Karen Moredock, DCFS
Heather O'Donnell, Thresholds
Debbie Pavick, Thresholds
Jennie Pinkwater, IL Chapter AAP
Jay Powell, AmeriHealth Mercy
Mary Reis, DCFS
Julie Ross, Abbott Diabetes Care
Joel Roth, U of Chicago Medicine
Phyllis Russell, ACMHAI
Susan Sommers, HCSC/BCBS of IL
Margaret Stapleton, Shriver Center
Bernadine Stetz, Molina Healthcare
Rebecca Thompson, Progress CIL
Matt Werner, Consultant
Sarah White, Abbott
Brenda Wolf, La Rabida Children's Hospital

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II. Introductions

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

III. Director's Report

Director Hamos reported that it had been a very painful legislative session with some very serious work in developing a plan for \$1.6 billion in budget reductions. This is something that no state has ever had to do on this scale. It was a big challenge to do and will be a bigger challenge to implement. There was an attempt to look at providers for whom we were concerned to maintain access for our clients. As a result there are no great cuts for physicians, FQHCs, dentists, safety-net hospitals and rural access hospitals.

HFS must file rules as part of the Save Medicaid and Resources Together (SMART) act by the end of the month. Greg Wilson stated that in order for implementation, the proposed rule changes need to be filed 10 days before the effective date. HFS would also be filing permanent rule changes at the same time. Director Hamos added that there would be a 45 day comment period for the permanent filing. The SMART act link is <http://www2.illinois.gov/hfs/agency/Pages/Budget.aspx - proprules>

IV. Guest Speakers – The managed care experience in Pennsylvania

Dr. Pont had suggested looking at the managed care experience in Pennsylvania as this state is going down a similar path as Illinois in introducing managed care and has similar geography. Illinois is likely to have more managed care in heavily populated northern Illinois and the PCCM model would likely be more prominent in the less populated regions. Pennsylvania has a PCCM model run by Automated Health Systems covering the rural areas and 5 to 6 Managed Care Organizations (MCOs) covering Philadelphia and Pittsburgh.

Dr. Pont introduced Dr. Jamie Calabrese, Medical Director of Gateway Health Plan, Pittsburgh, PA and Kyle Fisher, Pennsylvania Health Law Project, Philadelphia, PA. He asked that each guest share their experience with managed care, identifying what works and what may be improved upon. Participants would be encouraged to ask questions afterward.

Dr. Jamie Calabrese comments

Dr. Calabrese began by reviewing that in the Philadelphia and Pittsburgh areas, the delivery system went from fee-for-service (FFS) to a managed-care model with different plans competing for business. The current plan is to go into rural areas starting on July 1 in the 7 counties near the Harrisburg area. Other counties in the western part of the state are expected to come on September 1 and the eastern part of the state by March next year. The entire state will be using MCOs by next year.

There are 9 MCOs in the state. Not all compete in all geographic areas. Gateway is providing coverage in several parts of the state. Evaluating the transition from PCCM to MCO depends on your perspective. From the health plan and budget perspective, the transition has been very good. A health plan study for the state found there would be a potential savings of \$2 billion if the whole state went to MCOs.

For a health plan, growth is good but also painful. The plan needs to have a network of providers in place before it can compete to get access to the counties. This can be a lot of work without the plan knowing if they will get anything out of it. The state will then set the payment rates and the plan must decide to work with the rate or bow out. With the plan having a lot of investment before the bid, it is not often that an MCO would back out based on low rates.

Rates have a down flow effect. The MCO can only give providers what they get from the state. Gateway pays providers a capitated rate and some providers will balk saying they will lose money. Sometimes additional analysis is needed. For example, the hospital in Pittsburgh said they were losing money. Gateway

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reviewed a year of their claims data, calculating what they would have paid as fee-for-service (FFS). The review found that the hospital was 25% better off being in a capitated payment model.

For doctors, the only way to tell if they're better off under FFS versus capitation is to sift through the numbers. Some doctors are happy with capitation as there is a steady monthly payment. Some providers are happy that there is a state funded children's vaccine program as vaccines can be costly upfront to purchase.

Pediatric specialists feel the most short-changed and they probably are as the state rate is lower than the commercial rate. The specialists expect to earn more than the primary care doctors. They don't get a lot for consultations and surgeons don't get a lot for surgeries. That's just the reality. It is a balancing act. While no one is forced to work in the Medicaid program, the Medicaid managed care plans like Gateway have to be competitive enough to maintain a provider network. Managed care is advantageous for our members because of the care management and disease management programs. These are not provided under FFS. Our services that are above and beyond paying for visits save money and improve health outcomes for our members.

Pennsylvania is one of a few states that offer "family of one" provisions. A child with special healthcare needs is eligible for Medicaid regardless of family income. This makes a huge difference for middle class families in getting therapy, medical equipment, skilled nursing care and private health aides for children.

Our biggest frustration is that we have separate physical health and behavioral health MCOs for clients. The rules are such that we can't interact with each other or know what members are doing. Gateway is responsible for all pharmacy including psychotropic drugs that psychiatrists write for our members. However, the psychiatrist can't find out if the prescriptions are being filled and we can't find out why the drugs are being prescribed.

Kyle Fisher comments

The Pennsylvania Health Law Project (PHLP) is a state-wide legal services organization fielding roughly 3000 client calls per year. It serves as counsel to the consumer subcommittee of the statewide MAC and meets monthly with the state on the Medicaid program. This gives us both a policy and an individual case perspective on Medicaid managed care. Pennsylvania currently has the PCCM model in 42 rural counties. That is being phased out. Mr. Fisher provided some cautionary comments about risk-based managed care.

In Medicaid managed care, there is a business ethos introduced in negotiating rates for care that is different from the normal ethos around hospitals and providers accepting Medicaid patients. Under PCCM with FFS payment, a provider looks at the rate and decides whether or not to accept patients. This is not the case when you have a private entity coming in as a third party and being paid a capitated rate. We routinely see contract disputes between MCOs and hospitals which can disrupt care for clients and cause confusion. We expect to see more of this in the rural counties going forward with a statewide managed care model.

PHLP sees the MCOs using recipients as leverage in their contract negotiations. The largest MCO that dominates the market for Medicaid is currently negotiating contracts to recruit PCPs with the 3 area hospital systems. The process has been stalled for 6 months. One is a large prestigious academic health system stating it isn't going to assign patients to its members until there is a rate agreement. This has affected the hospital's bottom line as it hasn't been able to get patients from that MCO for 6 months. This has limited choice for consumers and is contrary to best serving Medicaid recipients.

The MCOs' interest is aligned with the state over consumer interests when enrollment is frozen. An MCO felt it was experiencing adverse selection by getting the sickest members. As a remedy, the plan took no new members for 9 to 12 months and new members were assigned to the 2 other MCOs in the service area. This enrollment freeze limited consumer choice. As the state moves to more mandatory managed care, the program is promoted as increased choice through competition. Potential cost savings is not being promoted.

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Another issue is the suitability of managed care in rural areas. The state offered voluntary managed care in some 17 to 25 of the rural counties that had the PCCM model. The voluntary MCOs had very little enrollment and were unable to build a very large provider network. Gateway Health Plan decided, after 3 straight years of financial losses, to pull out of 17 counties. Some recipients lost their connection to their doctor as they were not accepting fee-for-service Medicaid patients.

PHLP routinely sees service denials that it believes may result from the MCO trying to save money at the expense of patient care. To recruit more providers, MCOs may pay more than the fee-for-service amounts. If the state is paying the MCOs less yet doctors are being paid more, then savings have to come from somewhere. Plans have to consider cost and the claims that providers are submitting. Mr. Fisher believes the savings are coming from utilization review. PHLP regularly sees this in service denials. It is frustrating as PHLP often sees cursory denials like “not medically necessary”. There is a need for state oversight. PHLP is concerned that as the state agency shrinks there are not enough state employees overseeing the utilization review by the plan to ensure that service denials are not done inappropriately.

Q: What did Pennsylvania do regarding continuity of care when voluntary managed care enrollment is low (about 15%) and the state is moving from a PCCM model to a MCO dominated model in urban areas and MCO blend in the rural areas? What strategies were employed? Are there any statistics about how many people had to find a new provider because of an insurance switch?

A: Dr. Calabrese was not aware of any data about persons forced to find a new provider but stated that the consumer has the upper hand with at least 3 MCOs competing in every county. The consumer could look at the panel of doctors that each MCO offers. If the doctor allows FFS Medicaid, they likely have at least one MCO contract. There should be little disruption, at least at the primary care level.

When Gateway first goes into a county, they see a lot of non-participation authorizations to ensure continuity. As the MCO becomes established, you see that number go down. Gateway will approve out-of-network care to maintain continuity. If there’s a conditional that is particularly complex the MCO will continue that non-participating care indefinitely. The mantra is to do what is right for the member.

Gateway pulled out of 17 rural counties as it wasn’t getting significant volume. There wasn’t motivation for members to enroll in a capitation plan requiring them to get prior authorization to see a specialist when the FFS choice didn’t require that. With MCOs competing against MCOs the playing field is much more level.

A: Mr. Fisher pointed out that with medically frail patients having multiple providers it is less likely that all their providers will be enrolled with an MCO. Pennsylvania does have some continuity of care rules in place. The state allows 60 days to find another provider for patients that have an established relationship with a non MCO enrolled provider and encourages the MCO to recruit that doctor into its network.

Q: Dr. Pont asked about special needs children getting service and the Special Needs Units (SNUs).

A: The Gateway health plan has nurses and social workers in the SNUs. Every child’s status is reviewed at least once a year and often more frequently. There is a care coordination conference to look at what a child needs and what services they are getting. They will analyze why there may be multiple hospital or ED (Emergency Department) admissions, asking what they can do for the high cost child both to reduce cost and improve care. The approval rate for service requests is one of the highest in the company.

Q: Is there is a separate MCO handling a child’s mental health needs?

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A: Dr. Calabrese responded that unfortunately, there are separate behavioral health MCOs. When these kids have behavioral health issues, we can tell only by seeing their medication profile. We ask the parents if they'll talk to us. All we can do is see if we can help the child get into the behavioral health system in a better way. We don't know if the patient is taking the meds or if their PCP is prescribing the same meds.

Director Hamos added her concern with that approach and her belief that we would want a more unified approach in Illinois. She also wished to make sure that people were aware that the department was successful in changing the law last year to allow for exchange of clinical information on behavioral health records for Medicaid clients. She believed that there would be a new push as part of the Illinois Health Information Exchange (HIE) to allow for full exchange of clinical data so that all the providers who work with people with behavioral health needs will have access to clinical information.

A: Mr. Fisher agreed that Gateway does a good job with special needs children but that is not necessarily true across the board with other MCOs. Some plans visit a child, while others may only initiate telephone contact. It's best to ensure that care coordination responsibilities are spelled out in the MCO contract.

Q: Is there a way to ensure that enrollees go to their assigned health plan providers? What happens when an auto-assigned recipient goes to a provider outside the network?

A: Dr. Calabrese used the example of a parent taking their child to a doctor with whom the child has an established relationship rather than to the MCO assigned doctor whom the child has never seen. The doctor will likely find that the child is not on the membership list and say either you could change to me or I'll try to get a pre-authorization for the current visit. The plan often approves the out-of-plan payment once to allow for a PCP change. If the child is not in network and it is not an emergency, the child may be turned away. There is no obligation to see the child.

Q: Is there a different capitation rate for the special needs children? If not, isn't it counter-intuitive to pursue special needs children for enrollment?

A: There is not currently a risk adjusted capitation payment, but we are working on it. Gateway has a dual-eligible contract with a rate adjustment for Medicare services. We're looking at using the same model in our Medicaid business.

A: Pursuing special needs children for enrollment is more a hardship for the provider as it is the same per member per month (PMPM) amount regardless if the child is healthy or special needs. Gateway gets back some reimbursement from the state to partially cover our nursing hours, medical daycare and home health aides. We have learned to manage it and it's part of our mission to care for the poor and indigent sick.

Q: Is there is a lock-in period where you must stay with the MCO for a year?

A: There is no lock-in period. The individual could change every month.

Dr. Pont added that he was initially very concerned when the Illinois PCP edit was turned on that persons would be going to the wrong doctor. Through a stakeholders' meeting and data provided by Dr. Kirkegaard, the notion of enrollees running from doctor to doctor wasn't as big a concern as initially thought. Dr. King's point is well taken that people are used to going to the right doctor under PCCM. The challenge going forward to a Medicaid managed care model is to ensure there is as much continuity of care as possible.

We want to ensure to the extent we can that when a patient is switched to an MCO that this change is accepted by the physician. There is another layer that when the health exchange comes on board we will have people switching back and forth from the commercial insurance world to the Medicaid world. It will be

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important to ensure continuity of care for those members. Dr. Pont was pleased that the department's Bureau of Managed Care also saw this as an important issue.

Dr. Calabrese added that churning for persons that hover around the top of the eligibility cut-off is a big issue in Pennsylvania as well.

Q: When a patient seeing a doctor every 3 weeks is moved to a capitated program and the regular doctor is paid less than under FFS, would the doctor reject a patient because they will be paid less?

A: Gateway doesn't see that. The counter argument is that the provider is paid monthly for a healthy child that may only be seen once a year. The individual doctor must look at the whole package and realize in the long run they are making a profit. The University of Pittsburg hospital PCP panel, representing 36 large practices, found that they came out about 20% ahead in the capitated model.

Gateway's PCPs are paid on a capitated basis. Most hospitals are on DRG (Diagnosis-Related Group) payment, although some are per diem. Specialists are paid fee-for-service.

Q: Dr. King asked if the state funded vaccine program include adults. What have you seen in terms of any changes in the quality of care people are receiving, utilization and customer satisfaction?

A: The vaccine program is VFC (Vaccine for Children) and covers only children up to 21 years of age. There is no equivalent program for the adult population.

A: Dr. Calabrese believes that the managed care service quality is better than FFS. Gateway credentials all their enrolled physicians and has been told that the standards are tougher than for most commercial plans. Under the "Gateway to Physician Excellence" program, we put out quality measures at the beginning of the year and pay at the end of the year to incentivize quality care. If a pediatrician's patients are getting immunizations, well exams and a strep test before getting antibiotics, you'll get an extra check from Gateway at year's end. In the adult world, if the provider is doing PAP smears, screening for colon cancer and all the usual adult well-care, there is also an annual bonus payment.

A: Mr. Fisher stated that in looking at HEDIS data for the PCCM and Managed Care programs, the data was comparable and the quality was relatively the same. From a consumer satisfaction perspective, the PCCM program scored slightly higher but not a great difference.

Q: Do you see an integrity issue in a capitation model for PCPs where a provider will game the system to do the best they can to collect the capitation check which will far exceed the amount of care they're giving and render the quality measures tangential at the end of the year?

A: Dr. Calabrese stated that some people out there may do that but would disagree about reimbursement. If the provider is not giving the vaccines and EPSDT service, they won't get the incentive check.

A: Michelle Maher, Chief, Bureau of Managed Care, added that in the HFS Integrated Care program there is a risk adjustment done at the end of the year based on the level of need of the client. There are 2 health plans in the program. If the department determines that sicker clients pick one health plan while the health plans are paid the exact same rates throughout the year, at the end of the year the department's actuaries will adjust the rates retroactively to cover the sicker caseload. It really doesn't behoove either plan to try and get the healthier people as the rates will be adjusted accordingly.

Q: Dr. Groban commented that in terms of fee-for-service versus capitation for PCPs, it seems that the response in Pennsylvania is much more favorable than what we have for certain pockets of our state. The question is whether or not this incentivization or augmentation at the end of the year is the way to go.

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A: Dr Calabrese stated that Pennsylvania has not yet got to risk adjustment on their Medicaid business but thinks it is probably a better model. She believed that if there is adverse selection by a health plan, it is driven by the doctors in the community and the plan has to find a way to deal with it.

Dr. Pont added that at least the downside risk is minimized in Pennsylvania.

Q: A behavioral healthcare provider asked about the response of the MCO as you enter rural areas where there may not be the full array of services available to meet EPSDT standards?

A: Dr Calabrese stated in Pennsylvania there is a huge lack of adolescent and pediatric psychiatry. The Behavioral health MCOs are starting to do some telemedicine for child psychiatry. As an MCO, we have to have a network that can provide EPSDT services or we cannot work or compete in that county.

V. Review of January 10, 2012 meeting minutes

Dr. Pont stated that he didn't find the January meeting minutes included with the meeting agenda posted online. He suggested that the subcommittee table the review of the minutes until the next meeting.

VI. Update on Innovations Project

Director Hamos stated that the submittal deadline for the Innovations proposals was last Friday and 20 proposals were received. Some covered more than one area.

The submittal deadline for the dual-eligibles proposals was yesterday and 9 proposals were received. The department is working with the federal CMS on what the financial model will look like.

The Innovations project was launched on October 13 because the department wanted to give lots of time to providers to organize themselves. Right after that, the federal government launched the dual-eligibles project with very strict deadlines which are now somewhat changing. We had 2 things that came in almost the very same day. The dual-eligibles project that MCOs and MCCNs have applied for will take first priority as we are dealing with the federal government as well. After that, we'll come back to the Innovations project and hope to launch some of them by the beginning of next year.

A behavioral health provider commented that in looking at our data for the Innovations piece, 40% of their specialty population was dual-eligible. MCOs were shocked that a large portion of their potential population were receiving behavioral health services.

Director Hamos asked for feedback on the client data the department had shared with potential bidders. She advised that HFS was interested in putting out a survey to the proposers to improve its data sharing capacity. She noted that data analytics is an important part of HFS' mission. The department wants to learn from this and to ensure that HFS providers have the data for which both of us will be held accountable.

One person advised that the data was better than initially expected. It gave some good broad pictures of populations. The flags were useful but at times the data was hard to compile and cross-reference, in particular, the flags for pharmacy and diagnosis issues.

VII. Open to Subcommittee

Dr. Pont asked for ideas on what this subcommittee should be doing. The mandate from last March that created the subcommittee was pretty broad so any topic could be considered as a subject for a meeting. There was robust discussion on potential topics and several were identified.

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- A meeting on care coordination to prevent inappropriate ER use. Dr. Groban was concerned that the \$1.6 billion in savings identified by the state may really be less cost savings but more a cost shifting by driving care to emergency rooms.
- If the Supreme Court upholds the ACA, the department will expect to see 500,000 more Medicaid recipients in Illinois and it is likely that all persons added will be in care coordination. Director Hamos suggested that an interesting subject for discussion is where are the providers who are going to take this big new caseload. What might the providers and the offices and clinics of the future look like and do?
- Susan Greene suggested a presentation about the CCEs (Care Coordination Entities) that are chosen that could include a brief synopsis of their plans.

It was asked if HFS would publish the names of the entities that had submitted proposals for the CCE and dual-eligible contracts. Ms. Maher and Director Hamos advised that yes the names and addresses would be published this week on the care coordination website.

<http://www2.illinois.gov/hfs/publicinvolvement/cc/Pages/default.aspx>

Katie Galle asked about the next RFP for MCOs it was understood that the RFP would be released in late summer or in early fall. Do you have a clarification on the date?

Director Hamos wasn't sure which project she was referring to and reviewed the current care coordination projects:

- Integrated Care program for 40,000 senior adults and people with disabilities in suburban Cook and collar counties. Phase 2 will add long term care to the service package. This is important to implement as HFS is also implementing related changes under the class action Colbert lawsuit settlement. This encompasses persons of all disability types residing in nursing homes in Cook County and their desire to transition to a community setting. The MCOs in this program will do that review in the suburbs.
- The Dual-eligible care integration Financial Model Project for seniors and disabled covered under both Medicaid and Medicare.
- The Innovations Project providing organized care networks
- Care coordination for the rest of the state.
- Solicitation within the next couple of month to serve children with complex health needs

VIII. Next Meeting

The next meeting is tentatively scheduled for September 11, 2012 at 10 a.m.

IX. Adjournment

The session was adjourned at 11:40 a.m.