ILLINOIS DEPARTMENT OF
Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

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Memorandum

DATE: June 28, 2013

TO: Members of the MAC Care Coordination Subcommittee

FROM: Julie Hamos
Director

RE: MAC Care Coordination Subcommittee Meeting

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The next meeting of the Medicaid Advisory Committee's Care Coordination Subcommittee is scheduled for Tuesday, July 9, 2013. The meeting will be held via video-conference from 10:00 a.m. to 12:00 p.m. Those attending in Springfield will meet at 201 South Grand Avenue East, 3rd floor video conference room. Those attending in Chicago will meet at 401 South Clinton, 7th floor video conference room.

Attached, please find the agenda for the meeting, and the draft minutes from the October 2, 2012, January 8, February 5, and April 9, 2013 meetings for review.

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.

This notice and the agenda have also been posted to the Department's Web site at: http://www.hfs.illinois.gov/mac/news/index.html

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

Medicaid Advisory Committee
Care Coordination Subcommittee

401 S. Clinton
7th Floor Video Conference Room
Chicago, Illinois
And
201 South Grand Avenue East
3rd Floor Video Conference Room
Springfield, Illinois

July 9, 2013
10 a.m. – 12 p.m.

Agenda

I. Call to Order

II. Introductions

III. Director's Report

IV. Review of Oct 2, 2012, Jan 8, Feb 5, and April 9, 2013 Meeting Minutes

V. Update on Care Coordination Projects
   a. Dual Medicare/Medicaid Care Integration Financial Model Project
   b. CCE's
   c. Complex Children
   d. CMMI

VI. Accountable Care Entities (ACEs) – SB26, Medicaid Expansion Bill

VII. Health Information Exchange

VIII. Open to Subcommittee

IX. Next Meeting

X. Adjournment

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
October 2, 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
Kelly Carter, IPHCA
Margaret Kirkegaard, M.D., IHC, AHS
Art Jones, M.D., LCHC & HMA

Members Absent
Ann Clancy, CCOHF
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
Mike O'Donnell, ECLAAA, Inc.
Janet Stover, IARF

HFS Staff
Julie Hamos
James Parker
Arvind Goyal
Robyn Nardone
Michelle Maher
Amy Harris
Pam Bunch
Andrea Bennett
Sherri Sadala,
Jennifer Partlow
Samiena Aghi
James Monk

Interested Parties
Greg Alexander, Community Care Alliance
Bill Baker SGA Health
Jane Bilger, Consultant
Karen Brach, UHC
Peggy Brand, Celgene
Debbie Broadfield, IADDA
John Bullard, Amgen
Chris Burnett, IARF
Carrie Chapman, LAF
Matt Collins, HealthSpring
Mike Cotton, Meridian Health Plan
Cathy Cumpston, DHS/DMH
Elyse Forkosh Cutler, Advocate
Claudia Donds, HealthSpring
Andrew Fairgrieve, HMA
Eric Foster, IADDA
Barry Fitzgerald, Harmony
Neil Flynn, HealthSpring

Interested Parties Continued
Jill Fraggos, Lurie Children's hospital
William Gerardi, Aetna
Donna Gerber, BCBSIL
Barb Haller, IHA
Barbara Hay, FHN
Joe Holler, IHA
Marvin Hazelwood, Consultant
Beth Horwitz, Heartland Alliance
Teresa Hursey, Aetna
Nicole Kazee, U of I Health System
John Jansa, Molina Healthcare
Judy King
Marissa Kirby, IARF
Keith Kudla, FHN
Joseph Linn, Abbott Diabetes Care
Mara Martin, PHRMA
Kevin Mc Fadden, Astra Zeneca
Robert Mendonsa, Aetna
Mike Murphy, Meridian
Ena Pierce, HealthSpring
Jay Powell, AmeriHealth Mercy
Joel Roth, U of Chicago Medicine
Ken Ryan, ISMS
Donna Scherer, DSCC
Margaret Stapleton, Shriver Center
Bernadine Stetz, Molina Healthcare
Matt Werner, Consultant
Cynthia Waldeck, Heartland Alliance

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
October 2, 2012

I. Call to Order

Dr. Pont called the meeting to order at 10:07 a.m.

II. Introductions

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

III. Director's Report

Director Hamos reported that the department had met with the Legislative Medicaid Advisory Committee (LMAC) yesterday. Since the last subcommittee meeting, the department has written the needed State Plan Amendments (SPAs) for the federal government and, written rules that needed to be submitted to the Joint Committee on Administrative Rules (JCAR). Many of the 62 items that were included in the SMART act required one or both. The department is waiting for the federal approval for the SPAs, but proceeded anyway to move on implementation for July 1.

Staffing of the Bureau of Managed Care will double during this next year. HFS wants a strong bureau to work with the various care coordination entities as they come online and as HFS rolls out the next stages of care coordination. HFS has a national consultant looking at how those kinds of bureaus can be organized.

HFS has been working with JCAR on some issues for rules they prohibited. The department is working with the Illinois Hospital Association on some of the SMART act provisions that are causing some concern. Some have written to HFS as new provisions take effect expressing concern on how they may impact. The department has talked to LMAC and providers about how HFS is not in a position to make those provisions go away or to negotiate or compromise on them. The department looks to our legislators to give us some back-up. The legislators are very focused on the bottom-line. They want to know how HFS is doing with cost savings. It is hard to know that just three months in. If you are reaching out to us, please understand the position HFS is in, feeling very much accountable to the legislators who put a lot on the line in trying to achieve Medicaid program cost savings.

IV. Review of January 10, 2012 and June 20, 2012 meeting minutes

There was a motion which was seconded to approve the two months minutes. Dr. Pont asked for the addition of a statement on page 5 of the June minutes. Dr. Calabrese was asked if in Pennsylvania there is a separate MCO handling a child's mental health needs. She answered that unfortunately there are separate behavioral health MCOs. He wished the minutes to reflect the director's expressed concern with that approach and her belief that we would want a more unified approach in Illinois.

The director agreed with this statement. 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.

Dr. Pont called for a vote on the minutes including this modification. The minutes were approved.

V. Update on Duals Project

James Parker, Deputy Director of Operations, reported that HFS has two projects for which we are close to announcing awards. These are the initial solicitation for Innovations for which HFS received 20 proposals from provider based organizations statewide and the dual capitation Medicaid Alignment Initiative (MMAI). HFS plans to announce the dual capitation alignment awards within the next 2 weeks. Staff have

done the preliminary scoring and had some discussions with the federal CMS. HFS is getting clarification on some of the policies from CMS in regards to the status of some of the plans. We are getting final updated information on networks. There is a meeting scheduled to begin final discussions of the status of all the bidders. For the care coordination entities proposals, our hope is to get out announcements by the end of this week. The plan is to make an initial set of awards. Entities that do not get an initial award may still receive an award at a later date. The department has tried to pick the best handful that we think are most ready to move forward and HFS has capacity to handle. There is a lot of work in setting these up including setting up connections with the HMOs.

Q: Dr. Pont stated that we had talked in this subcommittee about having some kind of website/clearing house where members of the community as they decide which CCE they may want to join could find out some of the specifics of what the CCE would focus on, what their strengths were and maybe something about provider networks. Is that in the works?

A: The department had put out a brief description of each of the CCE proposals like the geography covered, main collaborators and target populations. As HFS makes the awards, we can see if there is more information to put out there so people know what they are. As we get toward enrollment, the department will be developing enrollment materials that fully educate clients on who the CCEs are and what they do including their network. We'll have to do that to work with the client enrollment broker (CEB) to ensure that they have the information so clients can decide. The department can add to what is on the website. Information about the Care Coordination Innovations Project can be found here: http://www2.illinois.gov/hfs/publicinvolvement/cc/Pages/default.aspx . The document Mr. Parker referred to can be found here: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Documents/cc_solicloi.pdf

Q: Director Hamos asked what Mr. Parker is hearing now about when CMS is going to make decisions. When HFS announces awards will we have a pretty good sense that the feds will also approve this.

A: We are working with CMS on some issues about which plans are eligible for awards. Illinois and no other state other than Massachusetts had actually been officially awarded the Medicare-Medicaid Alignment Initiative (MMAI) demonstration. Until we sign a Memorandum of Understanding (MOU), we don't have the official go ahead from CMS. HFS is currently negotiating that MOU and target getting it signed this month. There is a strong certainty that Illinois will get an award.

Q: How will the mandatory enrollment policy work?

A: The department decided to make managed care enrollment a mandatory policy for the SPD population who get Long-Term Supports and Services (LTSS). In order to do that for duals, we needed a waiver. For the Medicaid only SPD, the department doesn't need a waiver as we have already done this with the Integrated Care Program. We decided to mandate duals into HMOs for LTSS in conjunction with the MMAI demonstration because the federal government modeled MMAI as an opt-out program meaning people may opt out at any time. HFS can passive enroll duals but they will always have the option of opting out or change plans every month on the Medicare side. To stabilize that situation, the department has decided to mandate that enrollment on the Medicaid side for LTSS.

VI. Preventing inappropriate ER use with Care Coordination

Dr. Pont introduced the topic. He stated that everybody is interested in reducing inappropriate use of the emergency room (ER) or emergency service department (ED). It saves money. It gives better patient care. It is better for the patient when services are provided by or together with the primary care physician (PCP).

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
October 2, 2012

We have four different people representing four different organizations to talk about care coordination and ER utilization. While speakers may talk about care coordination in general, the primary interest is how to we keep people who don't need ED out of the ED. How do we better communicate with the PCP so that can be achieved? What are the incentives or disincentives in their current systems to make this happen?

- HFS Spreadsheet: The meeting materials included a handout titled, "Outpatient Emergency Room Usage by Month, Pre- and Post- SMART Act Changes". Mr. Parker explained that the information had been requested separately from today's presentations. He advised that the chart shows decreases in ED use from April through August but it would be difficult to draw too much meaning from the data, as there is a lag time from when services are provided and claims data. A suggestion was made to show data on a per 100,000 person format to control for changes in the overall Medicaid population.

- All of the speakers used PowerPoint presentations. While hardcopies were not available, HFS has since posted them to the website. http://www2.illinois.gov/hfs/SiteCollectionDocuments/100212macpresmat.pdf

- Elyse Forkosh Cutler, Vice President for strategic planning and network developing at Advocate Health Care explained that Advocate is taking an enterprise approach to care management. She gave an overview of the Enterprise Care Model and how Advocate is thinking about decreasing inappropriate ED use.

  Advocate has the largest Accountable Care Organization (ACO) in the country. It has worked with Blue Cross Blue Shield (BCBS) for two years to move from a volume-based payment methodology towards value. The BCBS contract is a total cost of care/shared savings model. Patients qualify for ACO as either in an HMO or in a PPO with two PCP visits with an Advocate associated provider within 24-months.

  In July, Advocate entered the Medicare shared savings program and is just beginning to determine what will work for Medicare patients in an ACO model. Advocate is focusing on its current work as an ACO and doesn't plan to pursue a managed contract for the Medicaid population at this time.

  Some of her key points:

  - ECM is an approach to managing high-risk patients by providing information and assuring a smooth handoff across the provider continuum.
  - The challenge is getting the right level of care at the right time – all the time.
  - Advocate receives 24-month claims run for every enrolled patient. One issue is the lag time in getting claims data.
  - Major program components are: Enterprise Care Management (ECM), Care coordination tools and Care management analytics.
  - The data analytics piece allows Advocate to not only know what care patients are getting in the network, but also what care they are getting across the market place including ED.
  - Using this data allows Advocate to see trends in patient services and allows the PCP to contact patients or the family to see what is needed to better manage services and keep them out of the ED.
  - When patients are recruited for care management, Advocate talks about working on behalf of the specific PCP rather than calling on behalf of the insurance health plan.
  - In addition to claims data, outpatient ECM staff meet with practices to review high risk patients

- It is important for the ACO to know the enrolled high-risk patients via risk stratification. In the PPO group, 2.4% of the population are very high risk and account for 27% of the cost.
- There are 102 care managers, each with 125 high risk patients. What is unique is that each care manager is linked to an individual PCP as either embedded in a larger practice or in smaller practices the manager is dedicated and may use telephonic case management.
- Data reports show that our program is doing a good job in lowering hospital stays and managing readmissions but we are not doing as well in reducing ED visits. The strategy for improvement is to get data out to the hospitals and practices to focus them on where we have issues.
- Advocate is currently conducting a phone survey with high ED use patients to determine why there is high usage and how they may receive better coordinated care. This discussion may bring the patient into the case management program.
- Physician Performance Report cards make data available to providers and show what is going with their patients as far as utilization. Advocate has physician coaches that go to the practices to share this information including data that shows which patients are high ER users. This helps to develop strategies to reduce the ER visits. This can be viewed here: http://www2.illinois.gov/hfs/SiteCollectionDocuments/100212macpresmat.pdf

Dr. Margaret Kirkegaard, Medical Director of Illinois Health Connect (IHC) stated that she would speak broadly about IHC as a primary care case management (PCCM) model, care coordination models utilized by some other states, and then more about activities with IHC.

PCCM, when initially designed, had a parallel program called "Your Healthcare Plus" (YHP) that operated separately from IHC. It took on a lot of the care coordination roll for high-risk patients. The program provided a lot of foundational information and access to the medical home. There is a little bit of a gap now that YHP program has stopped, especially in regards to reducing unnecessary ED utilization.

Some of her key points:

- PCCM models are designed to enrich the medical home, allow for shared support networks and centralized services.
- There's a lot of emerging literature on the benefits of the medical home found online at www.pcpcc.net
- The medical home can be enriched by using population data like claims history; embedded case coordinators; case management fees (CMF); bonus payments; and by providing TA through field reps and QA nurses.
- A recent IHC survey showed that about 75% of our providers indicated that the bonus payments had motivated them to change their performance.
- To help with outreach, IHC provides monthly panel rosters that are updated daily and accessible through the states' MEDI website. The roster includes two contact phone numbers and a language indicator for English and Spanish.
- Rosters flag frequent ED patients, defined as 6 or more ED visits in the past year without a subsequent hospital admission. The roster has other clinical data that is preventive or primary such as well child screenings, mammography and PAP tests as well as the date of the last visit with the PCP.

- The panel roster is available in a format that is downloadable and allows a provider to sort data for example by frequent ED users and to do a mail merge facilitating patient contacts.
- IHC provides a "score card" on a semi-annual basis. This is mostly standard HEDIS measures and allows a comparison of performance to other providers and to statewide performance.
- In the last year, IHC has added an indicator showing ED visits per 1000 member months. Practices with a high number of ED users can be visited and given TA to look at ways of reducing ED visits.
- The ED visit indicator can't distinguish between appropriate or inappropriate ED utilization.
- IHC provides two years of claims history for each enrollee. Data is available online showing services but not test results. The data facilitates cost review and finding test results. Claims data provided by HFS is about 2 months old so not clinically relevant.
- North Carolina has the most fully developed shared support networks for Medicaid. A coalition of practices that serve Medicaid clients have a shared support entity that provides data, pharmacy evaluations, mental health services and connections. It took 15 years to develop.
- The North Carolina model has been distilled down into a kind of tool kit and implemented by Oklahoma and Alabama in just a year. Alabama claims decreased cost and ED visits.
- IHC is piloting with two hospitals to receive data directly from them to relay to the client and the PCP. This will also help with centralized care coordination allowing coaching on ED use when a client contacts the call center.
- Understanding when to go to the ED appears to be the most significant factor in ED use.

Robert Mendonsa, CEO of Aetna Better Health (ABH) gave an overview of the care coordination model. He then turned the presentation over to Dr. Gerardi, Chief Medical Officer, who talked about Aetna's ED experience in the Integrated Care Program and strategies to address ED usage.

Aetna Better Health covers about 18,000 Medicaid seniors and persons with disabilities. In this population, 0.7% account for over 15% of ED utilization. ED visits are 1100 per thousand compared to 200 per thousand in the commercial market.

Some of the key points:

- Members with the highest ED use are also persons with the highest risk for additional ER use and hospital admissions.
- The cycle of care management involves changing behavior through engagement to help clients become more resilient. Helping a client make better use of resources improves quality of life and saves money.
- Persons with the highest ED usage often have a very high level of severe and persistent mental illness.
- Persons with high physical health needs and severe and persistent mental illness benefit most from a community mental health center (CMHC) provider integrated with a clinical PCP capability.

Dr. William Gerardi stated that ABH views the ED visit as having a direct link to both admissions and readmissions.

- For our integrated model linking CMHCs and medical homes, capacity has been an issue. Despite a wide ranging network, the CMHCs are at capacity in our service area.

- The bulk of our ED visits are non-emergent. The diagnoses that members present to the ED are for things that could most often be handled in the outpatient setting by the PCP if the PCP knows about it.
- A challenge is getting information from the hospitals about when our members hit the ED. We get better information from the inpatient stay. Getting data from claims paid is a limiting factor.
- 134 of 18,000 members have 10 or more ED visits in 12 months. These people present a challenge as they are resistant to intervention by the hospital care manager, PCP or the plan.
- There is a great deal of variability at the individual physician level in terms of the ED visits per 1000. The plan is discussing pay-for-performance with PCPs that have higher ED use patients.
- Physicians caring for members are a first line of defense and have to be at the table. The best way to align incentives is through a shared savings model.
- The plan is unable to reach about a third of their members because of unstable addresses or intermittent phone numbers. The plan has experimented with a primary nurse model and using staff to complete a risk assessment to then transition the member to a case manager.
- The plan believes in an interdisciplinary approach. Case managers may visit members in the hospital who often have entered through the ED. Getting members engaged while there is a teachable moment.
- The plan has some case management staff co-located in clinical facilities. The plan gets good information to members about accessing services and to the provider about working with the plan.
- Members are more likely to answer phone calls from their physicians so our case managers have a better phone contact compliance rate when calls are made from the physician's facility.
- The plan has a crisis line that is primarily targeted to mental health needs that gets high utilization.
- About a third of the inpatient census is tied to mental health diagnosis. ABH is more aggressive in discharge planning by including the pharmacy team so a member gets transportation and can pick up prescriptions when discharged. ABH is also more liberal in assigning home health resources.

Dr. Art Jones, Chief Medical Officer of Medical Home Network (MHN) stated that he helped start an FQHC on the Westside of Chicago and worked there for 27 years. The FQHC had near global risk on their contracts with responsibility for ER care. A lot of what you see here is what we have learned at the community and provider level on how to manage ER care.

Some of his key points:

- Don't overload the PCP with information.
- There needs to be a shared savings financial model to effect change.
- People may inappropriately use the ED because their needs aren't being met at the medical home. These needs may include getting pain control, addressing behavioral health issues or treatment for other chronic diseases.
- We need to have providers that don't just schedule monthly home visits but are willing to respond to that person on an emergency basis. When people with chronic disease confined to their home getting home based community services get sick they are told to call 911 and go to the ER.
- A big problem for care coordination is waiting for claims based data. There's a need for real time alerts and data to be sent to the medical home when a member is in the ED. This would allow the medical home to push back data to the ER doctor or get the care manager to meet face to face with the patient.

- An important way to change patient behavior is to develop a personal relationship through face to face contact with the care manager.
- MHN is developing customized data reports to give the ER doctor what they want and need to see.
- MHN is giving direct data feeds to their 6 affiliated hospitals. The information is so valuable that other hospitals want to be on the system. MHN is targeting hospital where their members are likely to go.
- MHN is moving toward doing wireless monitoring in the home for heart and hypertension patients. This information is fed into the MHN data depository.
- Wireless monitoring is used to track dry weigh gain with a text message going to the provider when there is a 4 or more pound weight gain. The provider can check if an appropriate script has been filled.
- Rush hospital ED has a dashboard program that flags MHN patients so the provider knows that they can get additional information.
- The hospital is easily able to print out a form for the patient that gives information on the medical home and facilitates care coordination.
- A dash board report is available to the care coordinators to see which patients have been in the ER or hospital and discharged in the last 10 days. The MHN plan is to provide a financial incentive to the coordinator when a follow up contact is made within 7 days of the discharge.
- Care coordinators can sort data in different ways to plan coordination strategies.
- MHN is getting positive feedback from patients and medical homes on information provided to them.

Dr. Pont commented on the presentations. He was struck by how similar the presenters' comments were in defining the problem and their recommendations although representing different types of approaches.

He was struck by how important continuity of care is and that the medical home and primary care doctor is the cornerstone of how we will be taking care of patients. He has been reassured to hear the department's commitment to this continuity and that the department's approach to client enrollment will be correct.

Dr. Pont opened the floor for questions and comments.

Dr. Goyal commented that the presentations had some common themes like communication, collecting data and using nurses to minimize the problem. He felt that the slides could have been more readable but otherwise the presentations were excellent.

He added that while working for an FQHC in Iowa, some of the things done to reduce ER use were to: look at cultural change; use available electronic health records; audit those conditions such as asthma that resulted in ER use; add office hours in the evening and on Saturdays; conduct group visits within the clinics for persons with asthma, diabetes or for pregnant women, and; place a resident in the ER to first see patients and allow direct-admit patients or women in labor to bypass the ER process. These actions created good will with ED staff and hospital administration.

Q: For Aetna, **1)** when you stratify your membership what percentage is considered high risk and what percentage is medium risk? **2)** Of the total population you are managing, how many have active care management plans in place?

A: The percentage with highest risk is 1 to 1.5% although we are trending upwards. Medium risk is about 7 to 8%. **2)** We have about 1,900 active care management plans.

Dr. Kirkegaard commented that a key factor in all the presentations was data connectivity and that all of us are searching for a way to get beyond the limitations of claims data. It may be useful to have the state

Office of Health Information Technology (OHIT) give us a status on the Health Information Exchange (HIE). It would beneficial as we are all working with separate hospitals now but eventually the idea is that the hospitals are going to feed into the cloud and we are all going to have access to that information.

It was also recommended to include that the Metropolitan Chicago Health Information Exchange (HIE) of the Metropolitan Chicago Healthcare Council (MCHC). They have 74 hospitals signed up as members with 15 hospitals up and running and 30 by the end of the year. They are also signing up the physicians.

Q: Dr. King appreciated Dr. Jones emphasizing the importance of the medical home as a factor in keeping people from going to the ER, although she thought there may be patients concerned about privacy. What would be the process in letting people know that any hospital they go to will know their business?

A: Dr Jones responded that all information is HIPAA compliant and that the calls are coming from the patient's medical home. IHC patients have to choose a PCP so information is going to someone the patient has chosen. One survey showed that about 96% of patients know their PCP.

Chris Burnett noted that there is a statewide HIE meeting scheduled on November 1 with sites in Springfield and Chicago. There will be discussion about the Health Information Exchange, the proposed changes and details on the Behavioral Health Integration project. The meeting notice is online at: http://www2.illinois.gov/gov/HIE/Documents/BHIP%20Statewide%20Meeting%202%2011-1-12.pdf

Q: Margaret Stapleton asked what the emergency departments think about all this. Is there concern about how these changes may affect their operation when we read that many people go there unnecessarily?

A: Dr. Kirkegaard responded that there are a couple of ERs that advertise "no waiting rooms" or "text us to see how long you'll wait". Clearly the advertising is to solicit for the non-emergent patient. IHC had a presentation at our quality conference from a Rockford hospital that reduced frequent ED utilization but found as a result they lost revenue. A big confounding factor is the participation of the emergency rooms.

Barb Haller added that the Illinois Hospital Association recognizes that we are in transition between changes in the delivery systems that have to sync up with payment and reimbursement changes. They have to be in tandem, and then there will be some solution for this rock and a hard place.

Q: How did IHC chose the hospitals that it is connected with?

A: Dr. Kirkegaard answered that for the pilot project that shares real time data from the ER, it was people who volunteered when we were looking to do this. We tried to pick a rural hospital and a suburban hospital in the IHC network.

Affordable Care Act and the Future
Dr. Pont decided to forego this topic for lack of time

VII. Open to Subcommittee
This topic was foregone for lack of time.

VIII. Next Meeting
It was decided that Dr. Pont and department staff would determine the next meeting date off-line.

IX. Adjournment
The session was adjourned at 12:00 p.m.

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

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

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.

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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.

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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.

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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

Illinois Department of Healthcare and Family Services
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I. Call to Order

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.

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
April 9, 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
Mike O'Donnell, ECLAAA, Inc.

Members Absent
Ann Clancy, CCOHF
Vince Keenan, IAFP
Diana Knaebe, Heritage BHC
Jerry Kruse, M.D., M.S.H.P., SIU SOM
Indru Punwani, D.D.S., M.S.D., Pediatric Dentistry
Janet Stover, IARF

HFS Staff
Julie Hamos
James Parker
Arvind Goyal, M.D.
Michelle Maher
Jeanette Badrov
Sally Becherer
Molly Siegal
Sherri Salada,
Sameena Aghi
Kerry McKenzie
James Monk

Interested Parties
Arlene Gustafson, Molina Health
Geri Clark, DSCC
Laurie Cohen, Civic Federation
Sheri Cohen, CDPH
Cathy Crumpston, DHS/DMH
Elana Dean, Urban Health Initiative
Tom Erickson, BMS
Gary Fitzgerald, Harmony-Wellcare
Eric Foster, IADDA
Paul Frank, Harmony-Wellcare
Susan Gordon, Lurie Children's Hospital
Gretchen Grieser, CCHHS
Barb Haller, IHA
Marvin Hazelwood, Consultant
George Hovanec, ARHLCH
Thomas Jerkovitz, DSCC
Mary Kaneaster, Lilly
Andrea Kovach, Shriver Center
Keith Kudla, FHN
Dawn Lease, Johnson & Johnson
Mike Lafond, Abbott
Helene Lane, Molina

Interested Parties Continued
Phillipe Largent, LGS
Randall Mark, Cook County Health Services
Jim McNamara, ViiV Healthcare
Kelley Martin, Molina
Mona Martin, PHRMA
Ana Mejia, Senior Services Associates
Susan Melczer, MCHC
Emily Miller, IARF
Diane Montañez, Alivio Medical Center
Karen Moredock, DCFS
Michael Murphy, Meridian
Jewell Oat, CBHA
Tim O'Brien, Consultant
Kristen Pavle, HMPRG
John Peller, Aids Foundation of IL
Ena Pierce, HealthSpring
Dana Popish, BCBSIL
Sam Robinson, Canary Telehealth
Dee Ann Ryan, Vermillion County MHB
Amy Sagen, U of IL Health system
Belinda Schultz, U of C Medical Center
Christy Serrano, Ounce of Prevention
Kathryn Shelton, LAF
Sam Smothers, MedImmune
Chet Stroyny, APS Healthcare
Erin Vaughan, Astra Zeneca
Cynthia Waldeck, Heartland Alliance
Matt Werner, Consultant
B. White, Forest PHM
Roxanne Walston, Senior Services Associates
Erika Wicks, HMA
Brenda Wolf, La Rabida Children's Hospital
Joy Wykowski, CCHHS

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
April 9, 2013

I. Call to Order

Dr. Edward Pont called the meeting to order at 10:05 a.m.

II. Introductions

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

III. Director's Report

CMMI planning grant

Director Hamos reported that yesterday a very interesting meeting was held to introduce a new initiative that the Department sought from the federal government's Center for Medicare Medicaid Innovation (CMMI). It is a fairly sizable 6 month planning grant. The federal government is looking for HFS to not just focus on Medicaid but to bring together providers and payers, in a multi-payer, multi-provider strategy to look at outstanding issues like service delivery and payment reform. Payment reform would be an intense undertaking if done together with all parties to see if there are ways to pay for quality and outcomes rather than for quantity.

The Governor's office is convening this effort and Michael Gelder is the project director. Health Management Associates has been retained to provide staff support. It is structured around 3 different models. These are the: "P" structure, built around our Care Coordination Entity providers; "PP" structure built around providers and plans like Managed Care Organizations along with provider groups, and; "PPP" structure built around the Cook County Health and Hospital System as a provider, payer and health plan.

After the 6 month planning period, the federal government will pick a handful of states to test the new payment and service delivery models. Even if Illinois doesn't get that, HFS can think of it as a blueprint moving forward.

1115 waiver

Illinois is interested in applying for a new federal CMS 1115 waiver project. There is not much information about it at this point but the Governor's office has signed off on this and wants the Department to move ahead. The Director anticipates that in the next few weeks a draft concept paper will be ready. It will include some themes on what the Department would do with the waiver. The process begins with the concept paper being circulated with stakeholders for some initial input. The federal government would review and indicate if it is something they would be interested in. If there is interest, the Department would really engage the community and do a lot of different analysis to determine if the project would be budget neutral which means that during the course of the 5 year project Federal Medicaid expenditures will not be more than Federal spending without the waiver.

The waiver is different from the Cook County 1115 waiver, which is more of an eligibility waiver. This 1115 waiver is more of a transformation waiver and will probably include all of our Medicaid programs and related spending. Similar to the state of New York, Illinois went through this terrible budget exercise last year and is now saving a lot of money. HFS is putting clients into managed and care coordinated care that will also save some money. The Department is saying to the federal government that we would like them to reinvest some of those savings back into Illinois for some different priorities for Medicaid clients and to give the Department some flexibility to use those dollars for programs we know we need in Illinois.

The Department will have to comb through the budget to find every possible bit of spending now and find creative new ways to get the match. HFS is not talking about using the existing program match dollars but there are things in the HFS budget that if the federal government let us be more flexible we could match federal dollars to bring into Illinois under this 1115 waiver.

Q: There have been some concerns that the move to managed care could somehow affect the federal match we get as a result of the hospital provider assessment. Is this 1115 waiver being done to address some of those concerns and the federal match relative to that assessment?

A: As part of our hospital rate reform work and nursing home rate reform, what the Department knows is that part of the hospital assessment dollars are going to be above what is called the upper payment limit in about a year and a half as more cases go into managed care. The waiver does allow HFS to adjust for that.

IV. Budget Update

Director Hamos reported that she did not yet have a good sense on how the budget was going to work out. The Governor introduced his budget and it has been relatively quiet since then. There have been meetings before the various appropriations committees. HFS has been presenting a little on the budget. There have been some questions from advocacy and provider groups about the SMART Act and utilization controls from last year. The legislature is looking at what is doable and if any of those items can be restored.

V. Review of October 2, 2012, January 8, 2013 and February 5 meeting minutes

Since there was not a 6 member quorum, the minutes could not be approved.

Dr. Pont asked for clarification on the minutes from the January 8th meeting page 2. He understands that children with complex needs would be in care coordination but wanted to know if it is correct that children with no complex medical needs would also be placed in care coordination...

James Parker, Deputy Director of Operations clarified that all children in the regions with managed care would eventually be enrolled in care coordination. The regions include greater Chicago, Rockford, Quad Cities, Metro East and Central Illinois. Director Hamos added that since 1.6 million of the 2.7 million Medicaid enrollees are children, it would be necessary to enroll children to meet the state mandate that 50% of recipients be enrolled in a coordinated care system by 2015.

VI. Attendance - Quorum

There was concern about committee member attendance. There has not been a 6 member quorum for the last three meetings and only 5 committee members were present at this meeting. Dr. Pont noted that Dr. Kirkegaard has resigned from the committee leaving a total of 11 committee members. He advised that he would discuss member attendance with HFS staff offline.

VII. Update on Care Coordination Project

Mr. Parker provided the update.

a. Complex Children
The Department has received 7 proposals in response to the CCE for children with complex medical needs solicitation. There were 5 proposals from the Chicago area, 1 from Peoria and 1 from Macon County. The Department has completed preliminary reviews and high level summaries. HFS hopes to announce awards by the end of May.

b. Dual Medicare/Medicaid Care Integration Financial Model Project
The Department and MMAI awardees are working hard toward implementation. The Memorandum of Understanding (MOU) is out on the HFS website. The Department has received questions and is renewing the stakeholder's process. People may have received an email from the Director announcing the first meeting later this month. Invitations were sent to about 2,600 people. HFS will be having those meetings every other month. The focus at this next meeting will be on the enrollment process. There will be discussion on outreach and education to smooth the way for rollout to the dual-eligible

population. Director Hamos added that people may have received a second invitation that asks that people pre-register for the meeting in order to plan for the meeting space.

The Department recently received a federal document about the enrollment process. HFS is working through this document along with Maximus, the Department's contracted enrollment broker. Health plans continue to build their networks and providers should be hearing from them. Mr. Parker encouraged providers to contact him if they haven't heard from the health plans.

c. CCEs
HFS had made awards to CCEs last fall. The Department is working with the CCEs to get them up and running and particularly with the Macon County and Precedence CCEs so they are ready when HFS goes forward this summer with the mandatory enrollment of the Seniors and Persons with Disabilities population that are not dual eligible. HFS is very pleased with the CCE's efforts. HFS is grateful to have HMA helping to get the CCEs ready and appreciative of the work of Molly Siegal, the Department's CCE project manager.

d. CMMI
Mr. Parker referred to the Director's report on the new initiative from the federal government's Center for Medicare Medicaid Innovation (CMMI). Director Hamos added that the project in Illinois is called Alliance for Health. She added that the Governor's Healthcare Reform website would be updating information at: http://www2.illinois.gov/gov/healthcarereform/Pages/default.aspx .

VIII. Continuity of Care

Dr. Pont stated that that there is a historical change coming to the Medicaid program. In 2014 about 1.4 million Illinoisans' will be moved from their current model of health care to a multi-payer model. He advised that the challenge going forward is to make sure this process occurs as smoothly as possible.

Dr Pont referred to the University of Illinois at Chicago report that evaluated results from the first year of the Integrated Care program. The report showed no significant change in unmet need for enrollees so that patients are essentially receiving the same care. The report showed that member satisfaction has gone down so there more people that are less satisfied. Claims from out-of-network providers were close to 50%. The initial auto assignment rate was high at 70%. A significant number of people were taken from their medical home. He noted that this is bad and that we should not simply blame the providers but think of ways we can better work together. He offered 4 policy suggestions that are shown below with some of the group discussion.

1. **HFS should be more proactive and identify plans serving the different PCP panels and those people that will need to be moved. HFS should provide information to the individual practices as to which plans patients will be enrolled during 2014.**

Brenda Wolf commented that La Rabida Children's Hospital had been auto-assigned patients that staff have yet to find.

2. **The Client Enrollment Broker (CEB) process must be robust to provide options to enrollees and facilitate new enrollees staying with their desired PCP. It must contain current information regarding the plans' provider networks to minimize any inadvertent disruption in continuity of care.**

Mr. Parker stated that there is a roll-out schedule by population type for when HFS will be moving people. It shows a begin date but each process will happen over 6 month or more. There is also a cap on the number of persons that can be assigned to a provider.

He explained that when HFS goes to mandatory enrollment, persons will receive an enrollment package explaining the options in their region. They have a 60 day period to make a choice. The first letter gives the individual 30 days to choice a plan. The enrollment letter encourages the person to call the CEB. The telephone script directs the CEB to discuss the current PCP assignment and what hospital is of interest. If no choice is made, a second letter is sent. If no response, the person is auto-assigned. The process has an algorithm using the current PCP information to make the assignment to the plan their provider is affiliated with. It is important that providers sign up with a plan.

Mr. Parker explained that initially there was a lot of provider resistance. The Department and MCOs needed to look at where providers were philosophically. HFS anticipates that enrollment will be easier than in the PCCM start-up which was a wide open process. Now most children have PCCM assignments.

Dr. Pont suggested that the Department work with the state medical society to help with providers having panels of 200 – 250 patients to help ensure continuity of care.

Keith Kudla stated that the Department is concerned about network adequacy before rolling out a plan. This has been his experience with the Community Care Alliance in the Rockford area. A first step is to get information on the providers in a region to facilitate outreach.

Dr. Art Jones asked how difficult it would be to create enrollment package letters that show the assigned PCP and the plans they are enrolled in as a client wants to keep their PCP and join that network.

Mr. Parker responded that the PCP name and plan information is available but the Department wants the client to call the Client Enrollment Broker to discuss options.

Dr. Jones pointed out that the high default level has been a problem.

Mr. Parker responded that a large number of physician practices are owned by hospitals. Individual providers may say that they do not enter into the contract and that the plan representative must speak with the hospital.

Kathy Chan stated that she would be interested in the level of auto-assignment. She asked if there is patient satisfaction survey.

Mr. Parker didn't know if CSG is doing a client survey but auto-assignment is tracked. He believed that UIC is looking at those types of issues.

3. **There are patient populations that are generally low-risk, for whom the risk of disrupting continuity of care is outweighed by the advantages of care coordination. For those populations, a fee-for-service option should exist *if the PCP is not in the plan to which the patient is assigned***

Dr. Jones stated that a problem with not enrolling the low risk individual is that you want to know as soon as possible when the person moves from low risk to a higher level of care.

Another person added that ancillary services may be needed for a family but not available if left out of coordinated care.

Dr. Arvind Goyal, the HFS medical director stated that care coordination allows for some risk on the part of the provider. It is something to think about more. If a child is assigned and there is a change in the level of risk, there can be some modification after assignment. Assignment doesn't have to be a burden.

Dr. Jones recommended that the PCP that is concerned about continuity of care should sign up for at least one MCO so the patient may be auto assigned to them if no choice is made. There may be a problem that the PCP will take current patients but doesn't want new Medicaid. This can be addressed.

4. **HFS should work with providers to build a robust specialty care network by encouraging plans to appropriately reimburse specialty care. Access to specialty care will entice providers to join creating a "win-win" situation for Medicaid patients. Care management should be in cooperation with providers, as this is the best way to improve care coordination.**

John Peller stated that he is concerned about access to medications. What medications are on the plan formulary? Will that be taken into account?

Mr. Parker stated for MMAI the plan formularies are basically the same as for Medicare Part D. The plan pays for the drug the person was taking beforehand. He believed the transition period was 90 days. Coverage of AIDS drugs is likely comprehensive. For the Integrated Care Program, HFS reviewed the formulary to ensure it includes the same class of drugs as under Medicare Part D. The plan formularies were very close to the drugs coved under Medicaid.

One participant noted that things went OK with ICP but she has some concern with a larger number of enrollees. It can be a little difficult to find the formulary online.

Ena Pierce stated that there is information that HealthSpring would like to put on their website but is waiting for direction from the federal CMS. She stated that regarding the formulary the standard for Medicare Part D will apply.

IX. Common Goals from Plans

Ena Pierce stated that the MMAI plans have met twice and discussed standardizing billing information. They started by looking at how Aetna and IlliniCare have coded claims. The group would like a homogenized list of code sets for billing. The group is also looking at billing code standards for long-term care. The goal is to create one uniform document that is put in one place with a consistent set of tools. There is an opportunity for a subset of providers to have a uniform set of procedures. She added that prior approval guidelines are a special situation but it may be another place to look for some commonality.

Dr. Jones stated that other ideas for common goals for the plans are: Standardized credentialing; Common care plan platform mainly for care managers, and; Determination of need, should data be available to health plans.

X. Out Patient ER Usage

Mr. Parker referred to the handout, "ER Use Before and After SMART Act – by Age" that was included in the meeting notice package. He explained that the charts show monthly ER usage in the period from July 2011 through December 2012. He noted that the data for the most recent months may not include all the ER encounters. The charts show the number of total visits by type and an adjustment for visits per 1,000 enrollees. The data had been requested at previous meetings. He also referred to meeting notice a handout, "December 2012 ER Spike Check that compared ER visits by service type for November and December 2012.

Dr. Jones stated that an encouraging part of the Integrated Care Program is the reduction in ER utilization by 6% and an 18% reduction in hospitalizations.

Dr. Jones and Dr. Pont identified the jump in ER visits in December for acute upper respiratory infection and influenza as a reflection of the outbreak in influenza in that period.

XI. Open to Committee

Dr. Pont asked for suggestions for topics for future meeting. He stated that there had been some interest in having presentations on Electronic Medical Records (EMR) and the Health Information Exchange (HIE). It was suggested to invite Laura Zaremba with the HFS Office of Health Information Technology and Raul Recarey, Executive Director of the Health Information Exchange Authority.

Director Hamos suggested looking at what the Illinois Health Insurance Market Place staff is doing to roll-out the exchange.

Mr. Peller asked if the Department could provide feedback on the comments it had solicited on the Health and Quality of Life Performance Measures.

Ms. Wolf commented that there is a need for education for PCPs to understand the Department initiatives and what is needed to make them work.

Based on the group discussion, Dr. Pont advised that he would like a presentation on the Health Information Exchange at the next care coordination meeting.

XII. Next Meeting

The next meeting is scheduled for Tuesday, June 11, 2013 from 10 a.m. to 12 p.m.

XIII. Adjournment

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