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

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

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

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

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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).

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.