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**Medicaid Advisory Committee**  
**Quality Care Subcommittee**

April 16, 2019  
10:00 AM – 12:00 PM

James R Thompson Center  
100 West Randolph  
2<sup>nd</sup> Floor, 2-025  
Chicago, IL

And

201 South Grand Avenue East  
1<sup>st</sup> Floor Video Conference Room  
Springfield, Illinois

**Agenda**

- I. Welcome and Call to order
- II. Introductions
- III. Review of January 8, 2019 Minutes
- IV. Direct care delivery and social determinants of health in complex populations: A National Perspective on Model and Quality - Dr. Jeffrey Brenner
- V. Discussion to prepare recommendations regarding quality metrics
- VI. Adjournment

**Illinois Department of Healthcare and Family Services**  
**Quality Care Subcommittee Meeting Minutes**  
**January 8, 2019**

**Members Present**

Ann Lundy, Chair, Access Community Health Network  
Beverly Hamilton-Robinson, Human Services Consultant  
Tracy Smith represented Jenifer Cartland, Lurie Children's Hospital  
Traci Powell  
Kathy Chan, Cook County Health and Hospitals System  
Jason Korkus, Sonrisa Family Dental  
Andrea McGlynn, Cook County Health Plan  
Maryam Hormonzy, A Consumer Member

**Members Absent**

Catina Latham, University of Chicago  
~~HFS Staff Present~~ Chicago Family Health Center

Arvind K. Goyal	Sylvia Riperton-Lewis
Kyle Daniels	Bill McAndrew
Lauren Polite	Gretchen Vermeulen

**Interested Parties**

Diana Hasamear, IL Cancer Care	Janelle Hamilton, IL Cancer Care
Nicole Kazee, Erie Family Health	Tina Zurita, Next Level
Dianna Grant, Next Level	Garfield Collins, Next Level
Angela Perry, Meridian	Rebecca Aiken, Molina
Kris Classen, Molina	Terri Pokraka, BCBS
Carrie Muehlbover	Karolina Duszczak, IlliniCare
Meghan Carter, Legal Council	Martha Jarmuz, Choices
Emiliy Chittaja, LaRabida	Iveree Brown, Ounce of Prevention
Anna Carvallo	Nadeen Israel, AIDS Foundation of Chicago
Ann Cahill, Harmony	Yvette Ward, IlliniCare
Sally Szumlas, IlliniCare	Michael Lafond, Abbvie
Angel Miles, Access Living	Jon Jansa

- I. **Call to order:** The regular bi-monthly meeting of the Medicaid Advisory Committee Quality Care Subcommittee was called to order January 8, 2019 at 10:05am by Ann Lundy.
- II. **Introductions:** The Chair took role call for all HFS employees and Committee Members.
- III. **Review of October 9, 2018 Minutes:** The minutes from October 2018 were approved.
- IV. **Free Discussion:** It was discussed that MCOs should consider working with providers to reward members at the site of service for addressing care gaps. It was also brought up that continued transparency and collaboration would greatly assist both MCOs and provider to obtain better quality for members and patients.
- V. **LTSS Workgroup Report:** Quality Care Subcommittee member, Beverly Hamilton-Robinson, reported on this subject. The group has been reviewing currently available data, LTSS claims data 2014-2017, recipient-to-provider ratios by Illinois region by provider type, race and

**Illinois Department of Healthcare and Family Services**  
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ethnicity. The report has been completed. Ann Lundy will present the report to the MAC group for approval.

**VI. 2017 HealthChoice Illinois Plan Report Card:**

- a. MCO Challenges / Best Practices:** There were six presentations given: Terri Pokraka spoke on behalf of BCBS, Andrea McGlynn spoke on behalf of County Care, Sally Szumlas spoke on behalf of IlliniCare, Dr. Angela Perry spoke on behalf of Meridian, Rebecca Aiken spoke on behalf of Molina and Dianna Grant spoke on behalf of Next Level. Each of these presentations are attached.

**VII. Adjournment:** The meeting was adjourned at 12:02pm.

**VIII. Next meeting:** April 16, 2019 at 10:00am.

# Performance Measure Challenges and Best Practices

January 8, 2019

# Challenges

## Access to Care

- **Getting Needed Care**
- **Getting Care Quickly**
- Outpatient or Preventive Care Visits
- BMI (Adult)

## Women's Health

- **Prenatal Care**

## Living with Illness

- Comprehensive Diabetes Care (Dilated Eye Exam)
- Comprehensive Diabetes Care (Nephropathy Screening)
- **Controlling Blood Pressure**
- Diabetics Received Statin Drugs and Stayed on Them
- Living with Asthma

## Keeping Kids Healthy

- Well-Child Visits in the First 15 Months of Life
- **Childhood Immunizations**
- BMI Percentile for Children/Teenagers
- Counseling for Nutrition for Children/Teenagers
- Counseling for Physical Activity for Children/Teenagers

**Bold** = Our most challenging measures

# Strategies to Improve (Health Plan)

- Scheduled Medicaid HEDIS Summit for Jan. 28, 2019, with other Health Care Service Corporation (HCSC) Medicaid Health Plans to develop a strategic plan for the 2019 Quality Performance Measures.
- Implemented a work group with leaders from various operational and clinical departments, including Behavioral Health, Care Coordination, Utilization Management, Quality, Pharmacy and Provider Network. This work group will develop initiatives that focus on population health management.

# Strategies to Improve (Members)

- Added Performance Measure Care Gaps to the Care Management Database – Health Care Management
- Living365<sup>SM</sup> and PAVE<sup>SM</sup> Education Classes
  - These programs focus on common and complex diseases that require a higher level of members' understanding of their disease, medication, monitoring, exercise, diet, etc.
  - A partnership with Blue Cross and Blue Shield of Illinois and Jewel-Osco
- Partnered with Signify Health to complete in-home assessments (Preventive Visits)
- Implemented a Transition of Care team (Care Coordination) at the beginning of calendar year 2018 that manages the transition of care for members from one level of care to the next
- Healthy Incentives: Dilated eye exams, well-child visits in the first 15 months of life and mammograms

# Strategies to Improve (Providers)

- Hired field-based Quality staff who will educate providers on QI activities and initiatives
- Hired coders who will work with high-volume provider groups and assist field-based Quality staff with training providers to utilize care gap reports
- Implemented PAR (a provider database containing care gap data)
- *Provider Rewards* program (mammograms, dilated eye exams and well-child visits in the first 15 months of life)
- Behavioral Health incentive contract with providers to improve the rates of follow-up after hospitalization for mental illness

# Best Practices

Living365<sup>SM</sup> and PAVE<sup>SM</sup> Education Classes (a partnership with Blue Cross and Blue Shield of Illinois and Jewel-Osco)

Classes give members an opportunity to:

- 1) Take a “Healthy Eating” grocery store tour led by a registered dietitian who educates members about counting carbohydrates, types of fat, reading food labels, etc.
- 2) Engage with a Jewel-Osco pharmacist to learn more about diabetes and treatments, monitoring blood glucose and incorporating physical activity
- 3) Participate in a question-and-answer sessions
- 4) Receive free educational materials and items, including glucose tablets and gels, fiber supplements and diabetic skin cream



# Overall Performance

High and highest performance



Doctors' Communication and Patient Engagement

Women's Health

Keeping Kids Healthy



Access to Care

# Overall Strategies

## *Member Engagement*

- CountyCare Rewards – member incentive program
- Additional benefits
- Care coordination – provider-based/integrated health homes

## *Provider Engagement*

- Provider Incentive Program
- Provider-based Care Coordination

## *Systems*

- HEDIS portal (Vision)
- Real-time alerts portal (MHNConnect)



# Living with Illness

Members living with conditions, like diabetes and asthma, get the care they need by getting tests, checkups, and the right medicines.



## ***Promote needed care***

- Member incentive program
- New options for eye exams: primary care, in-home
- Specialized training for care coordinators
- Provider incentive program & performance reports

## ***More data to support performance improvement***

- Medication reports for providers and care coordinators
- Capture all lab and medication data



# Behavioral Health

Members with behavioral health conditions get the follow-up care they need.



## *Promote opportunities for follow-up care*

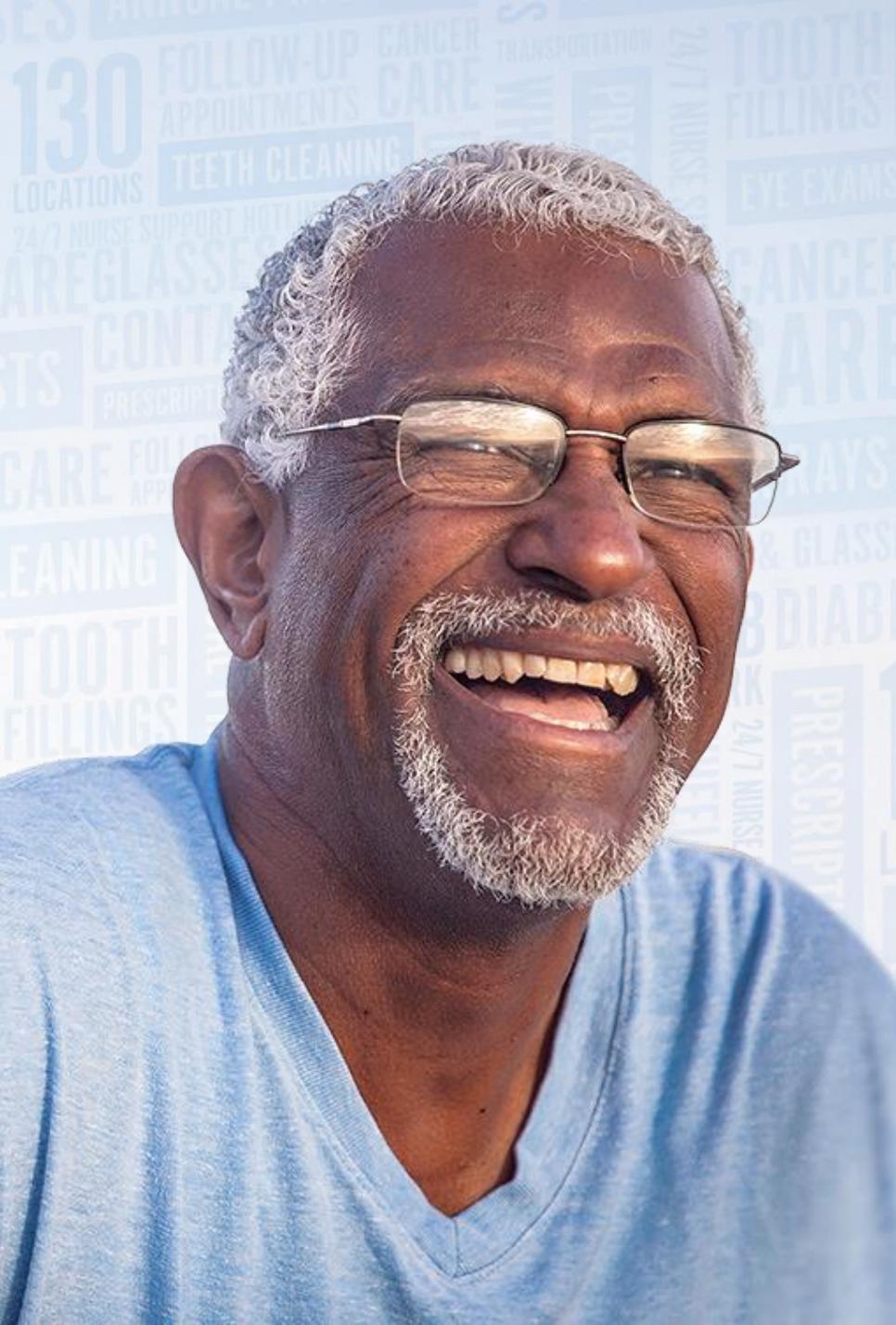
- Real-time alerts from BH hospital admissions
- Behavioral Health-Primary Care-Learning Collaborative
- Behavioral Health Consortium of Illinois
- Transition of care pilots

## *More data to demonstrate follow-up*

Members with follow-up not getting counted

- More detail on medical home/integrated care claims
- Capture all appropriate mental health agency claims





**5 Stars is our goal**

**Thank You & Q&A**



**CountyCare**  
HEALTH PLAN  
AN ILLINOIS MEDICAID HEALTH PLAN

# 2019 Quality Improvement Action Plan

**SALLY SZUMLAS RN MS, MPH, CPHQ**

**VICE PRESIDENT, QUALITY OUTCOMES OFFICER**

PROPRIETARY AND CONFIDENTIAL



# 2019 Roadmap to Plan Performance

New Plan Operating Model to Address Deficiencies



## Clinical Integration

Provider Network Performance

Product Margin Improvement

Operational Discipline

**Effectiveness  
x Scale**

**Physician  
Engagement**

**Focused  
Product  
Management**

**Infrastructure  
Optimization**

Outcomes:

- Integration of clinical team (Rx, MDs, Med Mgmt)  
Goal: *Achievement of clinically driven HBR savings and improvement year over year*

Outcomes:

- Lower PCP/SCP HBR  
- Increased # of VBCs  
- Increased payout of shared savings  
- Improved quality of care

Goal: *cost avoidance*

Outcomes:

- Increased profitable membership  
- Increase vendor effectiveness

Goal: *margin improvement*

Outcomes:

- Improved marketplace perception of ICH  
- Resolution of historical claims disputes  
- Improved timeliness & accuracy of all PDM loads  
- Goal: *50% reduction of provider complaints year over year.*

## Quality & Member Engagement – Fully Integrated

Outcome: Making quality “everyone’s job”; Integrating quality performance measures & outcomes into every area of the business.

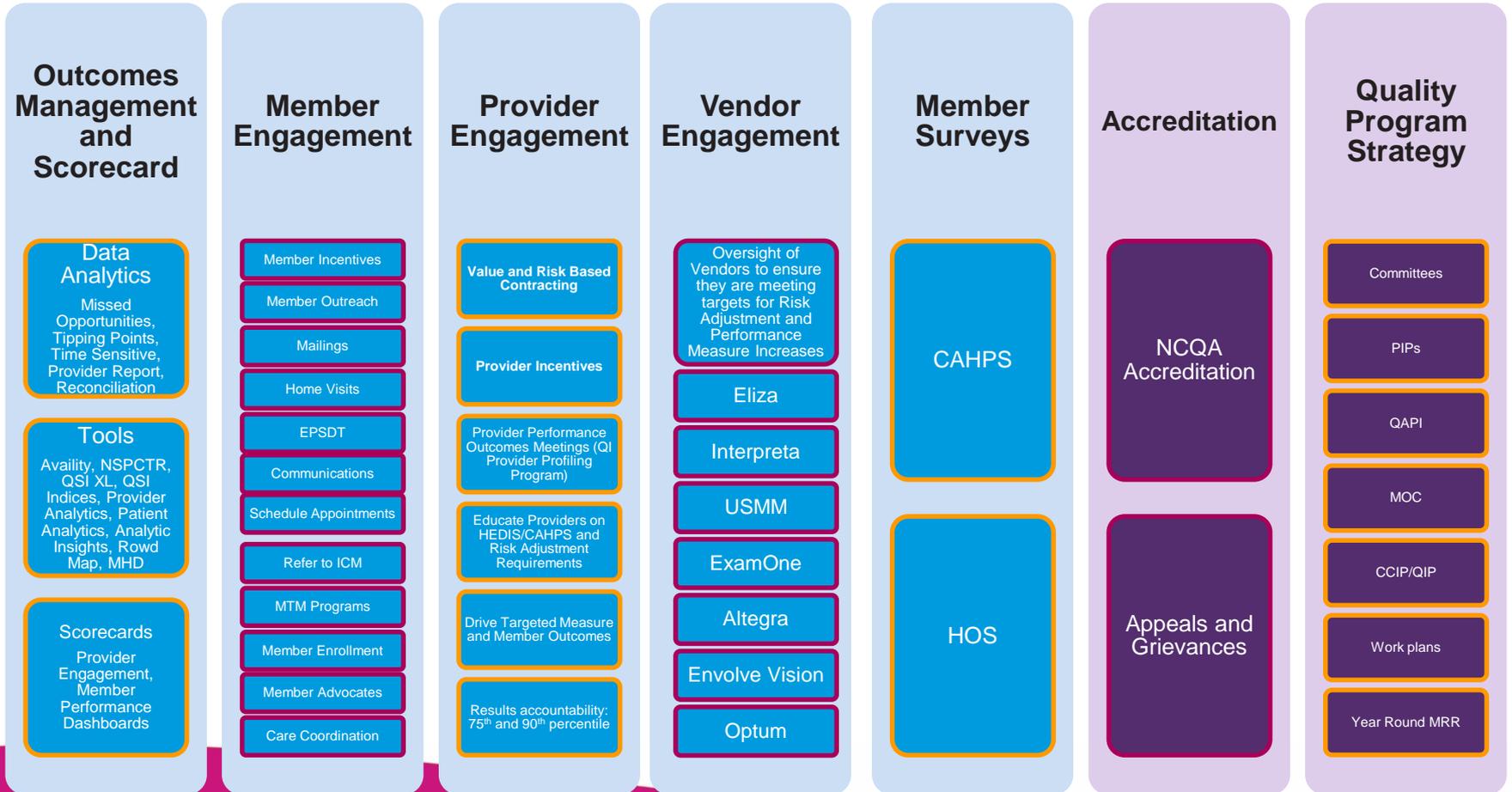
## Strategic Support – Always On Target

Outcome: Multiplying talent, leadership development around execution, and transparency of financial and compliance obligations.

# Quality

## Overarching Quality Engagement Model

### Quality and Risk



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# 2019 Improvement Tactical Plan

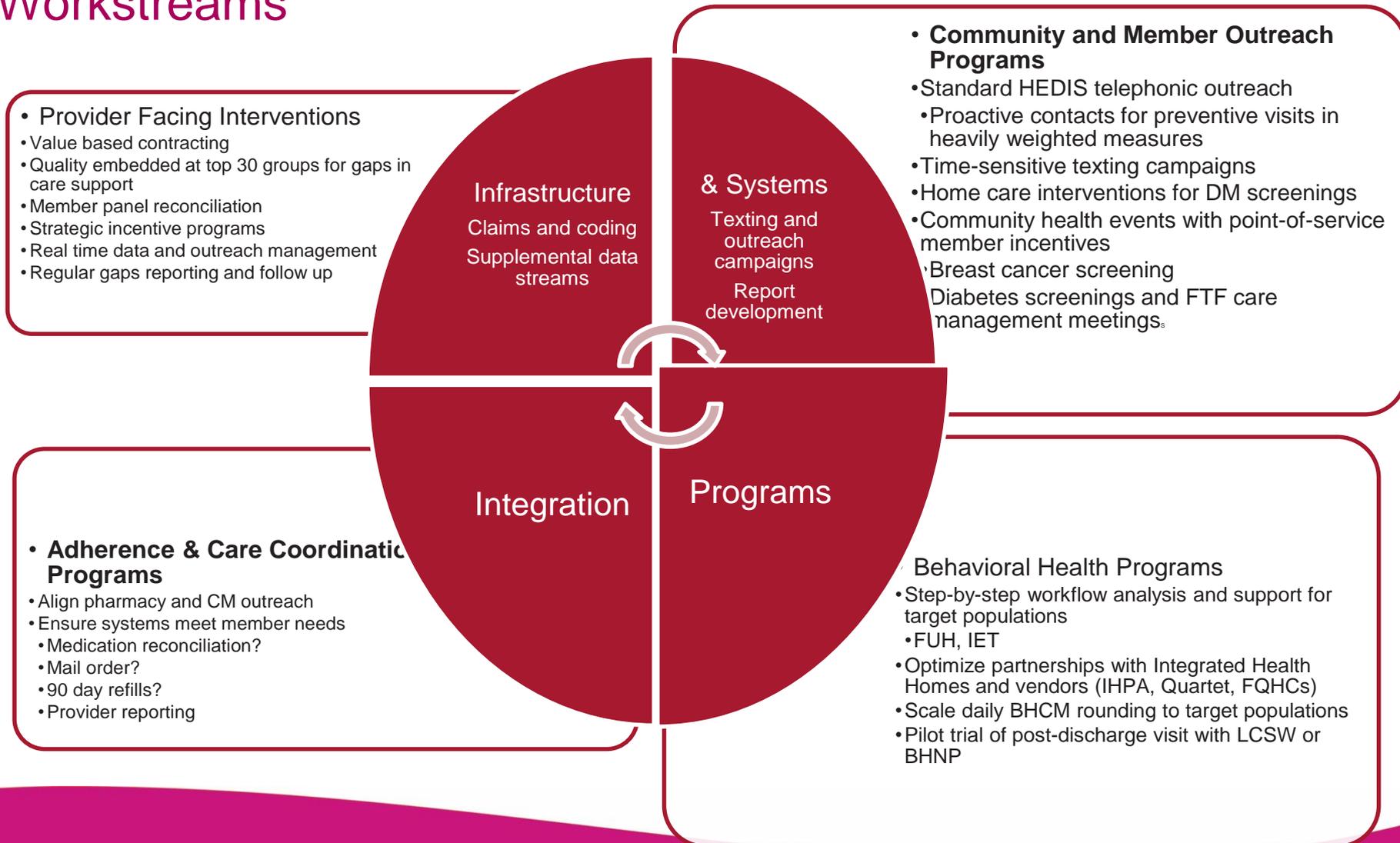
## System-Based

- Technology and Tools
- Provider and Member Incentive Programs
- Targeted Community Health Events
- Claims attribution
- Clinical integration strategies include HEDIS

## Measure-Based

- Rx / Adherence
  - Provider reporting
  - 90 day fills
  - Mail order refills
  - Care coordinator reports
- Provider Visits
  - Embedded outreach
  - Chart audits, claim coding
- BH / Serial Provider Visits
  - UM/CM workflow steps

# Performance Outcomes Steering Committee Workstreams



• **Provider Facing Interventions**

- Value based contracting
- Quality embedded at top 30 groups for gaps in care support
- Member panel reconciliation
- Strategic incentive programs
- Real time data and outreach management
- Regular gaps reporting and follow up

• **Community and Member Outreach Programs**

- Standard HEDIS telephonic outreach
- Proactive contacts for preventive visits in heavily weighted measures
- Time-sensitive texting campaigns
- Home care interventions for DM screenings
- Community health events with point-of-service member incentives
- Breast cancer screening
- Diabetes screenings and FTF care management meetings.

• **Adherence & Care Coordination Programs**

- Align pharmacy and CM outreach
- Ensure systems meet member needs
- Medication reconciliation?
- Mail order?
- 90 day refills?
- Provider reporting

• **Behavioral Health Programs**

- Step-by-step workflow analysis and support for target populations
- FUH, IET
- Optimize partnerships with Integrated Health Homes and vendors (IHPA, Quartet, FQHCs)
- Scale daily BHCM rounding to target populations
- Pilot trial of post-discharge visit with LCSW or BHP

# Challenges

## 1. Provider Engagement:

- Accurate group roster management
- Member panel management and outreach systems

## 2. Member Engagement:

- Mechanisms for successful contacts in hard-to-reach cohorts
- Accuracy of data transfer - historical claims and demographic data

## 3. Strengthening Community Systems

- Mechanisms to mitigate social determinants
- Community-based alternatives for care gaps



**866-329-4701**

(TTY: 711)

Monday-Friday 8:30 a.m. to 5 p.m.

**[IlliniCare.com](http://IlliniCare.com)**

# Key Opportunities and Planned Interventions for 2019

**Dr. Angela Perry**

*Market Chief Medical Officer*

# Overall Performance

- Five of the six categories have a 5-star rating on both Report Cards
  - Access to Care, Women’s Health, Living With Illness, Behavioral Health, and Keeping Kids Healthy
- One of the six categories, Doctors’ Communication and Patient Engagement, does not have a 5-star rating
  - 4-star rating on the Statewide Report Card
  - 3-star rating on the Cook County Report Card

# Doctors' Communication and Patient Engagement

*Cook County – Average Performance (3 Stars)  
Statewide – High Performance (4 Stars)*

## Barriers

- Provider payment delays
- Limited member outreach

## Interventions

- Strong Meridian Medical staff support
- Implementation of Quality Practice Advisors
- Multi-pronged member outreach

# Behavioral Health

*Cook County – Highest Performance (5 Stars)*  
*Statewide – Highest Performance (5 Stars)*

## Barriers

- Significant population growth
- Timely notification from providers
- Appointment availability
- Member education

## Interventions

- Provider Incentive
- EDI & ADT Feeds
- Provider Education
- Member Education
- BH Programs team

# Women's Health

*Cook County – Highest Performance (5 Stars)*  
*Statewide – Highest Performance (5 Stars)*

## Barriers

- Significant population growth
- Southern IL expansion

## Interventions

- New PPC Incentive Program
- Member HEDIS Events
- New vendor partnerships
- Increased member and provider engagement

# Molina Healthcare of Illinois Presentation to Medicaid Advisory Committee

1/8/2019 | Presented by: Rebecca Aiken

# Molina Healthcare of Illinois

## *2017 Scorecard – Plans for Improvement*

- A Culture of Quality Within the Plan
  - Provider Education
  - Health Plan Education
  - Workgroups
  
- Examples of Initiatives Planned for 2019
  - Behavioral Health Initiatives
  - Diabetes Initiatives

# Molina Healthcare of Illinois

## 2017 Scorecard – Plans for Improvement

### A Culture of Quality Within the Plan

- Launching a 2019 campaign to truly embed a culture of quality within the organization through ongoing staff education and participation in quality activities



# Molina Healthcare of Illinois

## 2017 Scorecard – Plans for Improvement

### Provider Education

- HEDIS Coding Booklet
  - Outlines all focus measures (Medicaid & MMP, included in P4P and not)
  - Includes description of each measure, and the associated diagnosis and billing codes
- CAHPS & ECHO Provider Tip Sheets
  - Offers tips for communicating well with patients to improve satisfaction
  - Information about appointment timeliness standards
- Pregnancy Rewards Toolkit
  - Information about Molina’s programs (Well Mom CM program, member incentive program)
  - Includes measure tip sheets and visit calendars from prenatal care to well baby visits
- Behavioral Health Toolkit
  - Guide for both BH providers and PCPs treating BH conditions
  - Includes BH HEDIS measure tip sheets
  - Provides BH assessment tools
- Flu/Pneumonia Toolkit
  - Provides updated CDC and ACIP vaccine recommendations
  - Offers tips for increasing flu and pneumonia vaccine rates

# Molina Healthcare of Illinois

## 2017 Scorecard – Plans for Improvement

### Health Plan Education

- Every Member Counts Campaign
  - Directed at all member-facing staff
  - Raises awareness about CAHPS and provides tips for ensuring member satisfaction
- Pregnancy Case Manager Education
  - Information and engagement strategies on the measures for prenatal, postpartum, and well-baby visits
- Respiratory Case Manager Education
  - Information and engagement strategies on the measures for asthma and COPD medications
- Recovery Awareness Month
  - Plan-wide staff campaign to raise awareness of recovery from mental illness and substance use disorder
- Behavioral Health Case Manager Education
  - Information and engagement strategies on BH measures
- Mammogram Case Manager Education
  - Information and engagement strategies on mammogram measure
- Diabetic Care Case Manager Education
  - Information and engagement strategies on diabetic measures

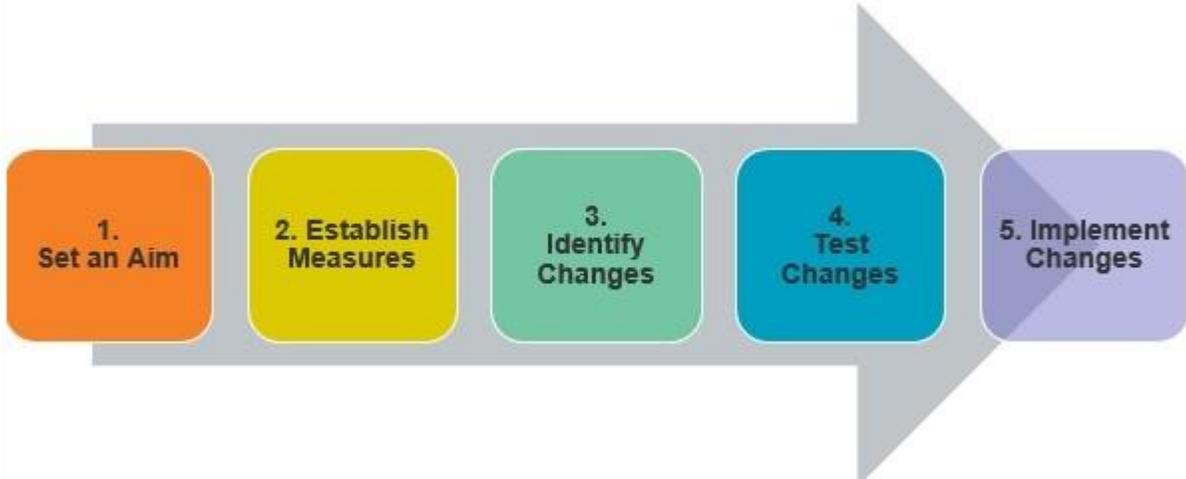
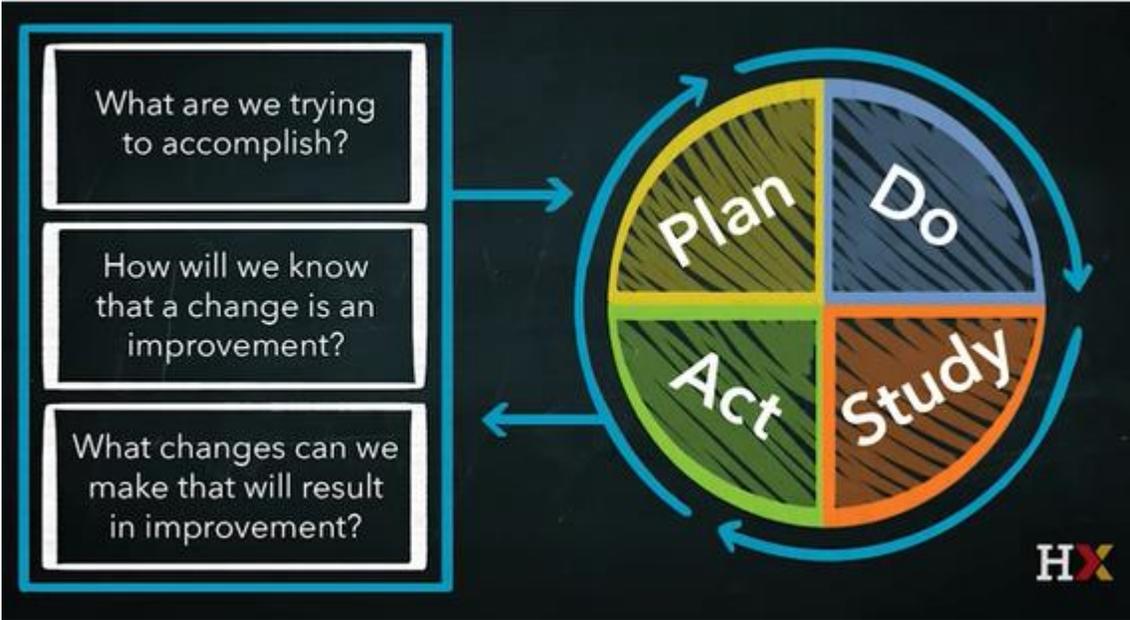
# 2019 Interventions Work Groups

- A quality lead facilitates each work group of interdepartmental subject matter experts
- Each work group is sponsored by executive leadership
- Measures grouped by topic or population
- Utilizes model for improvement

Work Group - Quality Focus	Goals
Wellness & Prevention	Improve member engagement with PCP, increase annual preventive visits and screenings
Mother & Infant Health	Improve mother & infant program, increase rates of prenatal and postpartum visits, increase immunizations and well-child visits
BH Quality	Improve rates of follow-up care and treatment in members with encounter for mental illness and/or substance use disorder, reduce behavioral health readmissions
Reducing ED	Reduce preventable ED visits
Chronic Conditions	Improve rates of testing, medication adherence, reduced admissions/readmissions for chronic conditions
Satisfaction & Experience	Increase satisfaction scores (CAHPS, PSS, ECHO), improve access/availability of care, identify & impact key drivers of dissatisfaction, improve communication to members

# Molina Healthcare of Illinois

## 2017 Scorecard – Plans for Improvement



### Behavioral Health Initiatives

- A more robust work plan to address behavioral health
  - Follow-up Care Rewards Program
  - Transition of Care Coaches outreach to members that are currently inpatient or are recently discharged
  - Case manager outreach to members newly diagnosed with alcohol or other drug dependence
  - Behavioral Health Provider Scorecards to with overall performance, goal setting and comparison to other competitors to spur improvement discussions
  - Provider tip sheet centered on questions on the ECHO survey to raise awareness of how they pertain to their practice and tips on how to improve satisfaction with their patients

### Diabetes Initiatives

- Examples of programs planned for 2019 to improve scores include:
  - Diabetes care reward program for testing and exams
  - Diabetes mail campaign that includes member education on annual dilated retinal exam and information on the nearest optometrist or ophthalmologist to the member
  - Diabetes outreach campaign for members that are identified as needing diabetic services
  - In-home visits for HbA1c testing, nephropathy screening and eye exams
  - Community events offering education, screenings and giveaways

# Molina Healthcare of Illinois

If you would like to participate in our  
Enrollee and Community Advisory Committee

Please contact

Raul Reyes

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Tammy Lackland

[Tammy.Lackland@MolinaHealthCare.com](mailto:Tammy.Lackland@MolinaHealthCare.com)



# NextLevel Health Report Card Update HFS/MAC Subcommittee

January 8<sup>th</sup>, 2019

Dianna Grant, MD – Chief Medical Officer  
Tina Zurita, RN – Director of Quality Management  
Garfield Collins – Chief Operating Officer  
Cheryl R. Whitaker, MD – Chief Executive Officer

# 2019 Key Focus Areas

1. Overview Summary
2. NextLevel – Report Card: 2017 vs. Present State
3. HEDIS Workplan
4. 2018 Strategy/Enhancements/Action Plan

# Report Card

## Past (2017 – 2018)

- MMAI Plan
- Bid for RFP
- Membership growth 29k to 50k by year end
- Successful RFP appeal
- New executive team
- HMO license granted
- Antiquated claims platform
- Insufficient data for reporting

## Present (2018)

- 50K members
- New claims/data platform
- Data in-house
- Improved data access
- Oversample for CAHPS to ensure sufficient data
- Executive sponsors for HEDIS measures = decrease barriers/increase access to provider data (EMR)
- Internal/external education on HEDIS and measures

## Future (2018 -2019)

- Continue to evaluate progress of strategies implemented
- Ongoing education on HEDIS and measures
- Increased collaboration with network providers
- Community awareness campaign

# NextLevel Health 2018 Report Card

HEDIS Key Measures	MY 2017	Nov 2018
WC15: Well-Child Visits in First 15 Months of life (6+ visits)	20.6 %	On Track
WC34: Well-Child Visits in the 3 <sup>rd</sup> – 6 <sup>th</sup> Years of Life	38.2 %	Ahead
AWC: Adolescent Well Care	16.5 %	Ahead
AAP: Adult Annual Wellness Exam	38.5 %	Ahead
CDC: HbA1c Testing	69.5 %	On Track
CDC: Eye Exam	17.0 %	On Track
CDC: Neph	84.1 %	On Track
BCS: Breast Cancer Screening	0.0 %	Ahead
CCS: Cervical Cancer Screening	21.1 %	Behind
PPC: Prenatal Care	52.3 %	Ahead
PPC: Postpartum Care	37.3 %	On Track
FUH: 30 Days	18.8 %	Behind

# NextLevel CAHPS & HEDIS SWOT

## STRENGTHS

- HEDIS auditors familiar with history
- We control & have access to our data
- Over sample of CAHPS survey
- Conducted 'spot member surveys' across all products
- Aggressive approach to identify specific disease population - diabetics
- Robust development of disease management program

## WEAKNESSES

- Prior platform deficiencies
  - Inability to access data
- Internal education around HEDIS and measures
- External communication/ education around CAHPS survey, HEDIS and measures

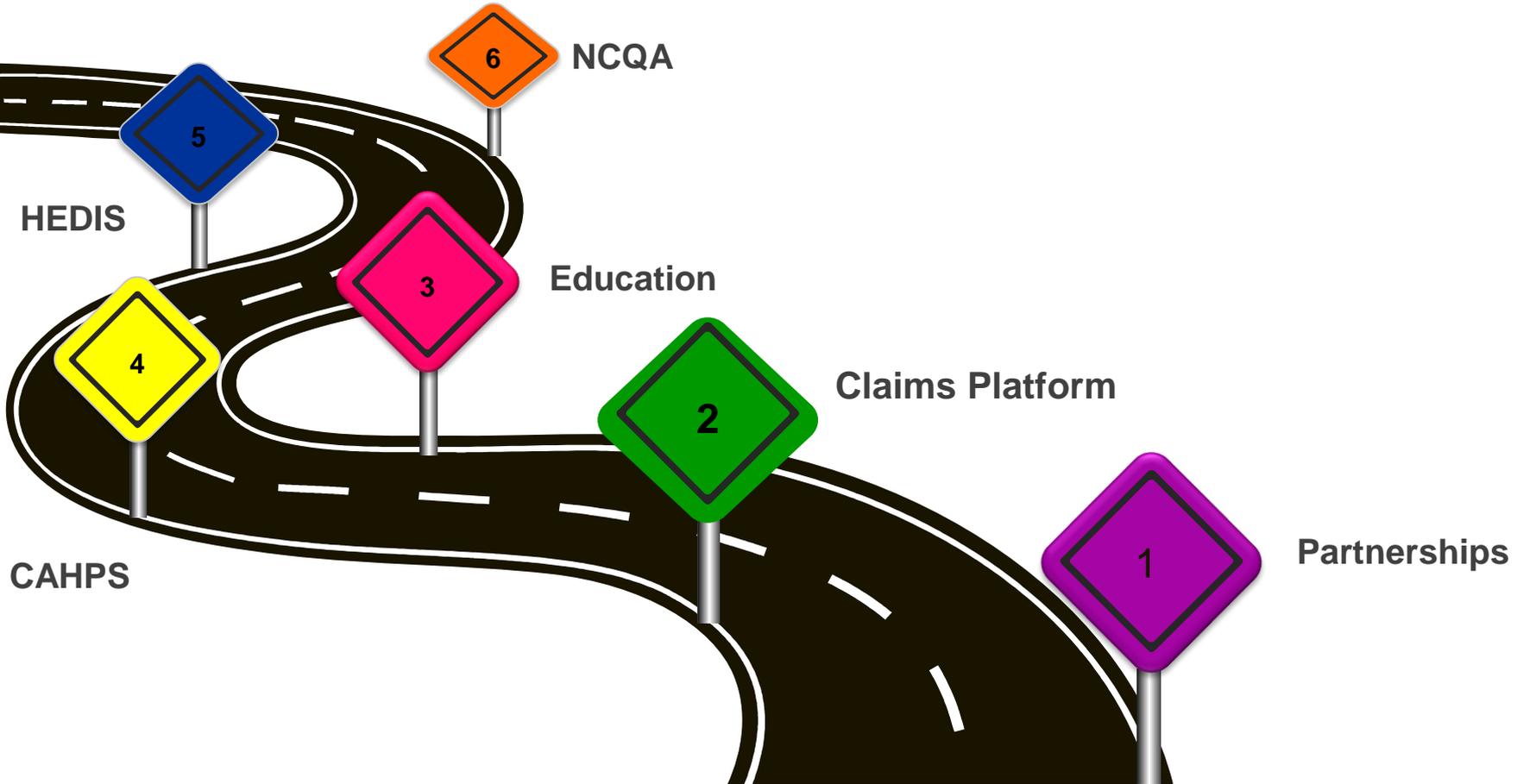
## OPPORTUNITIES

- Internal/external education around HEDIS and measures
- Continued oversampling for CAHPS survey
- Develop Member Engagement Services scripts around CAHPS and HEDIS
- New platform brings new opportunities

## THREATS

- Prior platform produced insufficient reportable data
- NLH did not have direct access to data which posed data integrity challenges
- Internal education around HEDIS measures
- External communication/ education around CAHPS survey and HEDIS

# Action Plan





# THANK YOU