ILLINOIS DEPARTMENT OF Healthcare and Family Services

Bruce Rauner, Governor
Felicia F. Norwood, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

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

April 3, 2018
10:00 AM – 12:00 PM

James R Thompson Center
100 West Randolph
2Nd Floor, 2025
Chicago, IL

And

201 South Grand Avenue East
1st Floor Video Conference Room
Springfield, Illinois

**Agenda**

I. Welcome and Call to order
II. Introductions
III. New Committee Members
IV. Review of January 9, 2018 Minutes
V. LTSS Workgroup Report
VI. Population Health – Reform to reduce disparities
VII. Adjournment



E-mail: hfs.webmaster@illiniois.gov

Internet: http://www.hfs.illinois.gov/

# Illinois Department of Healthcare and Family Services
# Quality Care Subcommittee Meeting Minutes
# January 9, 2018

**Members Present**

Ann Lundy, Chair, Access Community Health Network
Beverly Hamilton-Robinson, Licensed Clinical Social Worker/Human Services Consultant
Kathy Chan, Cook County Health and Hospitals System
Barrett Hatches, Chicago Family Health Center
Jennifer Cartland, Lurie Children's Hospital
Traci Powell, Harmony
Andrea McGlynn, Cook County Health and Hospitals Systems
Jason Korkus, Sonrisa Family Dental

**Members Absent**

Krishna Das, Cook County Health and Hospitals System
Catina Latham, University of Chicago

**HFS Staff Present**

Arvind K. Goyal (phone)
Kyle Daniels
Sylvia Riperton-Lewis
Cheryl Easton

**Interested Parties**

Laurel Chadde, County Care
Michael Lafond, Abbvie
Talya Hellman, ACCESS
Kate Maley, Shriver Center
Molly Hoffman, DSCC
Greg Johnson, ISDS
Phil Mortis, Gilead
Caitlin Lueck, Meridian
Emily Chittajallu, LaRabida
Jill Fraggos, Lurie Children's Hospital
Jill Hayden, Meridian Health Plan
Katie Shaffer, UIC – DSCC
Cyrus Winnett, IAMHP
Priti Patel – GEFCC



I. **Call to order**: The regular bi-monthly meeting of the Medicaid Advisory Committee Quality Care Subcommittee was called to order January 9, 2018 at 10:00am by chair Ann Lundy.

II. **Introductions:** A quorum was present. The Chair reiterated the goals of the committee are to serve in an advisory capacity and provide recommendations on the quality of the Medicaid program with an emphasis on vulnerable and high needs populations. The committee does not have an oversight role. The Chair also provided an overview of the key accomplishments of the committee in 2017 which included: Addressed gaps in the Diabetes Affinity Program; Provided recommendations for additional CAHPS survey questions for children with special healthcare needs; and established a follow up workgroup (see below) to review and provide recommendations on the implementation of long-term services and supports (LTSS), in light of a presentation that was made to the committee in October, 2017.

III. **New Committee Members:** The following new committee members were introduced: Catina Latham, Andrea McGlynn, Jason Korkus and Traci Powell.

IV. **Review of August 2017 and October 2017 Minutes:** The minutes from August 2017 were approved. The October 2017 minutes were approved with the condition that part five was to be

updated to reflect that the consumer report card provides less detail than previous year's and therefore is not the same.

**V. Implementation Long-term Services and Supports (LTSS) Workgroup:** Quality Subcommittee member, Beverly Hamilton-Robinson reported on this subject. The goal is to provide recommendations to the Medicaid Advisory Committee and to HFS on LTSS quality, including racial or ethnic disparity and delivery of services and to identify appropriate quality metrics. The objectives would be:

1. To review steps that can be taken to improve awareness of LTSS.
2. To review steps that can be taken to improve policy for financing affordability into agency implementation of the ADA, personal choice, delivery management equality of LTSS for seniors and persons of any age with disabilities who require LTSS.
3. Advise on the best ways to simplify interfaces between various state agencies and their divisions in the LTSS community.
4. Review and advise the department on the interface and coordination of LTSS in managed care entities.
5. Encourage development of quality programs for LTSS.
6. Make other identified recommendations to the Medicaid Advisory Committee.

In response to an audience question, the committee was informed that deliberations of the workgroup will be time-defined, and will report to MAC via the Quality Committee. A list of workgroup members will be shared once final. A Quality Subcommittee member requested that the workgroup also consider LTSS for individuals under waivers such as fragile x and other chromosomal disorders. The motion was made seconded and approved to move forward with the LTSS work group.

**VI. Population Health:** This presentation is now planned for the April 2018 Quality Subcommittee meeting and will focus on health equity and disparities.

**VII. Home and Community Based Services (HCBS) Summary:** The BQM Chief provided an update on the annual report for HCBS. All services provided by the MCOs are reviewed on a quarterly basis and the plans are required to implement a systematic quality improvement plan to improve outcomes. This year's report findings showed that eleven of the twelve performance measures averaged over 95% compliance for this past year. The one area that needs more work is the documentation of timely required contacts. HFS will be focusing on this performance measure in the coming year. A subcommittee member noted that the requirement for the frequency of contacts for HIV patients may be outdated since this is now typically a chronic, not acute disease. It was recommended that if it is in HFS' control, the Department should review the frequencies of contact for all areas to ensure alignment with current guidelines and conditions.

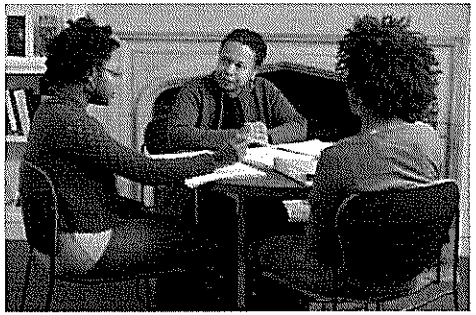
**VIII. Status of Provider MCO Complaint Portal:** The BQM Chief confirmed that the Department is in the process of developing new reports from the portal that will break down the information in a number of ways. These include: comparisons by quarter; timeliness for resolving complaints; and breaking down the complaints by types, program, and provider types. The analysis will also look at outlier. HFS will provide these reports to the plans. In response to an audience question regarding how complaints from dentists should be reported, HFS confirmed that all complaints should be reported to the MCO portal since all dentists are in the IMPACT system.

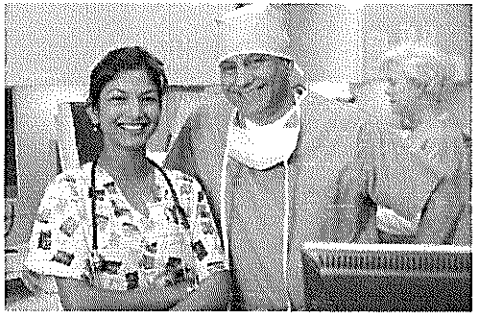
**IX. Status of CAHPS Questions**: Sylvia Riperton-Lewis confirmed that the six new CAHPS questions concerning children with special healthcare needs that were submitted by the Quality Subcommittee were incorporated into the new CAHPS survey that will be implemented in 2018.

X. **Adjournment:** The meeting was adjourned at 10:57am.

XI. **Next meeting:** April 3, 2018 at 10:00am.

# Solving Disparities Through Payment and Delivery System Reform: Implications for Managed Care Contracts



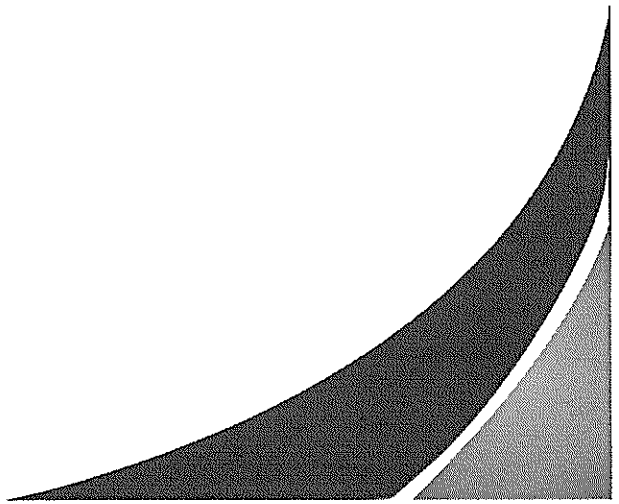
Marshall Chin, MD, MPH
Richard Parrillo Family Professor
University of Chicago

# Disclosures / Funding

- NIDDK P30 DK092949
- Merck Foundation
- Robert Wood Johnson Foundation
- AHRQ U18 HS023050
- CDC Community Prev. Services Task Force
- Co-Chair, NQF Disparities Standing Committee
- PCORI – Disparities consultant
- NIMHD National Advisory Council
- National Advisory Board, Institute for Medicaid Innovation
- Families USA – Equity and Value Task Force Advisory Council

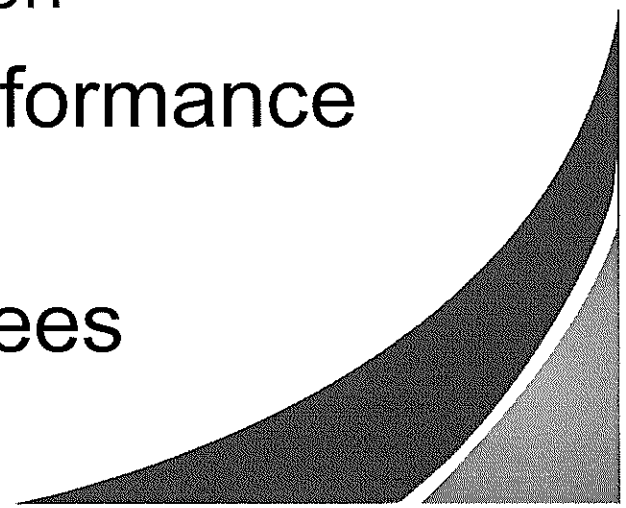
# Goals

- Review what is known about how to reduce health disparities and achieve equity through payment and delivery system reform
- Discuss implications of these health equity lessons for managed care contracts



# Agenda

- Define equity
- Conceptual framework
  - Health care and social determinants within context of history, culture, and values
  - Multiple levels of intervention
  - Place
  - Implementation science
  - Economic drivers and motivation
- National Quality Forum – Performance measurement and payment
- Early findings: 3 RWJF grantees
- Implications for IL HFS

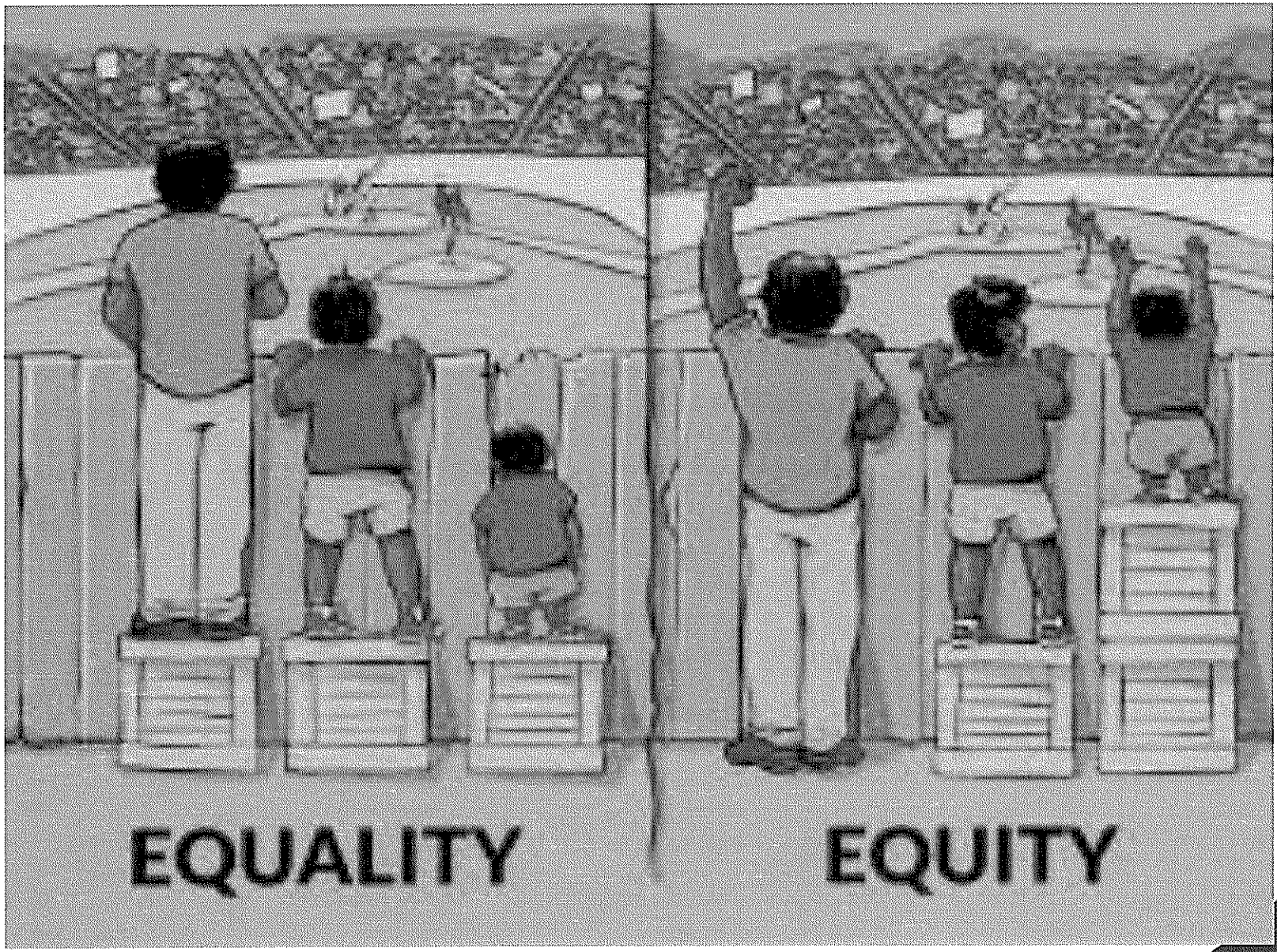


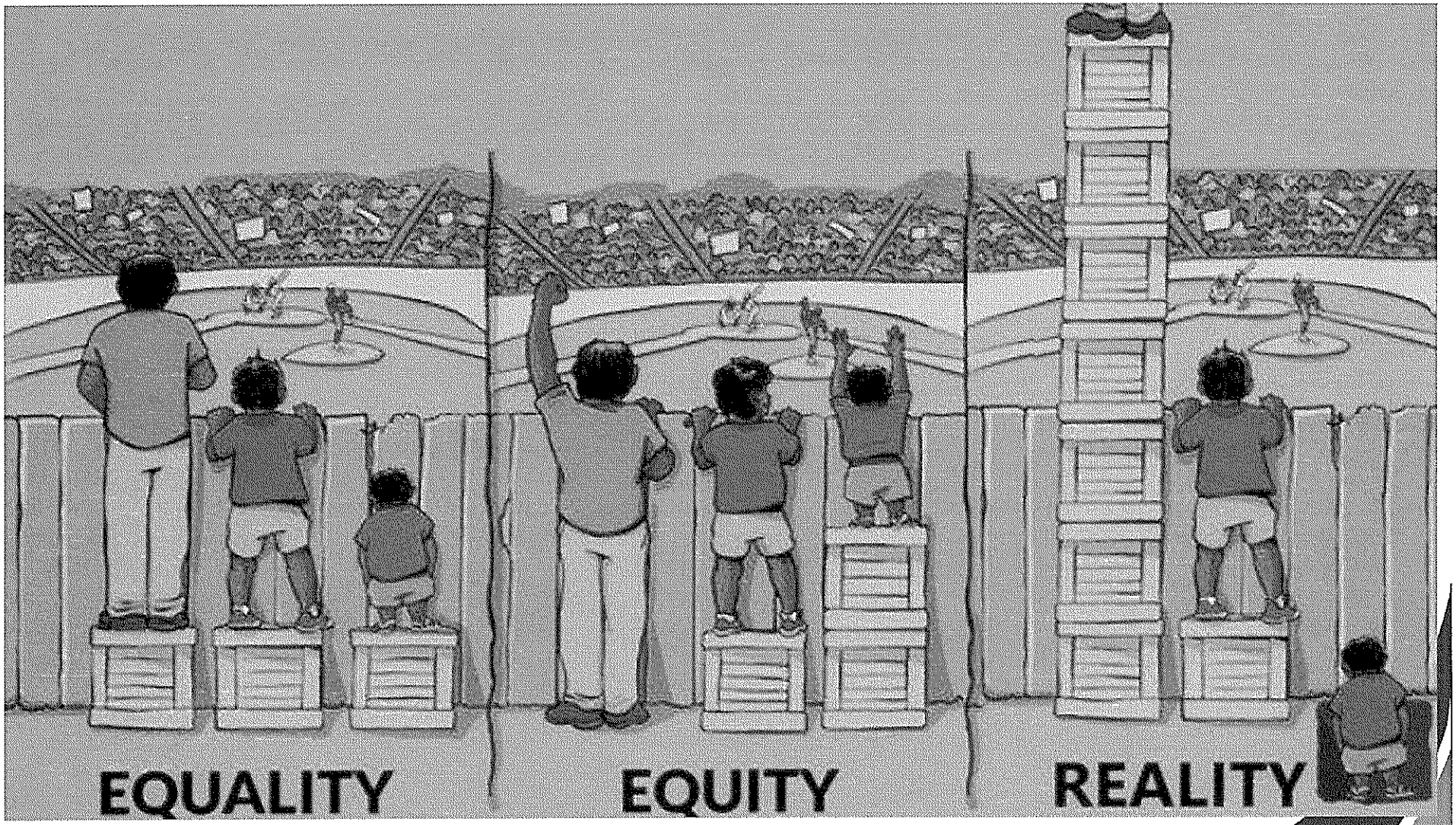
# My Perspectives

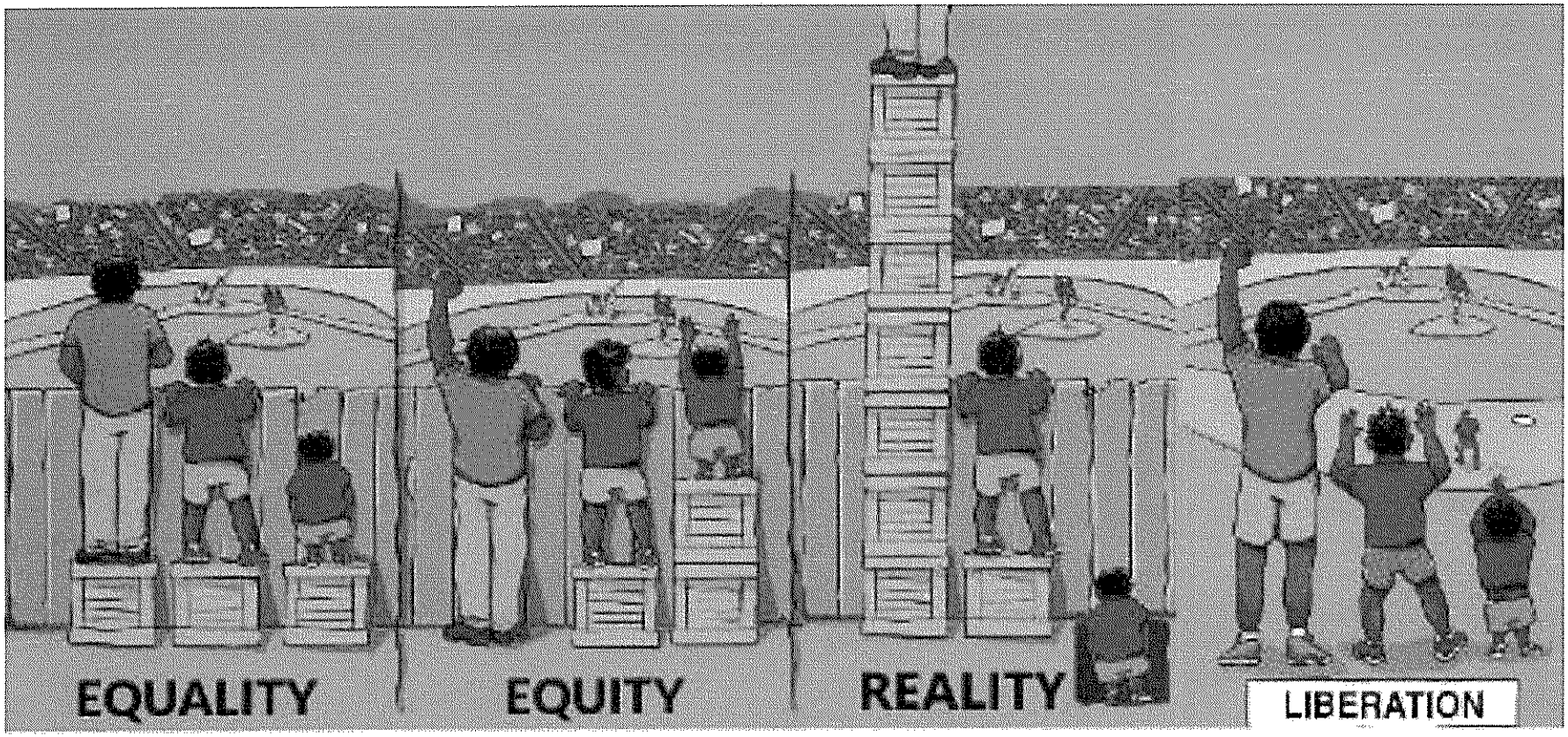
- General internist – urban academic centers in Chicago, San Francisco, Boston; Boston Chinatown CHC
- Multilevel, mixed method researcher
- RWJF Finding Answers – TA to frontline
- University of Chicago equity initiative
- Multistakeholder committees - e.g. NQF
- New Zealand and U.S. comparison
- Institute for Medicaid Innovation – Medicaid managed care plans

# World Health Organization

"*Equity* is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *Health inequities* therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms."

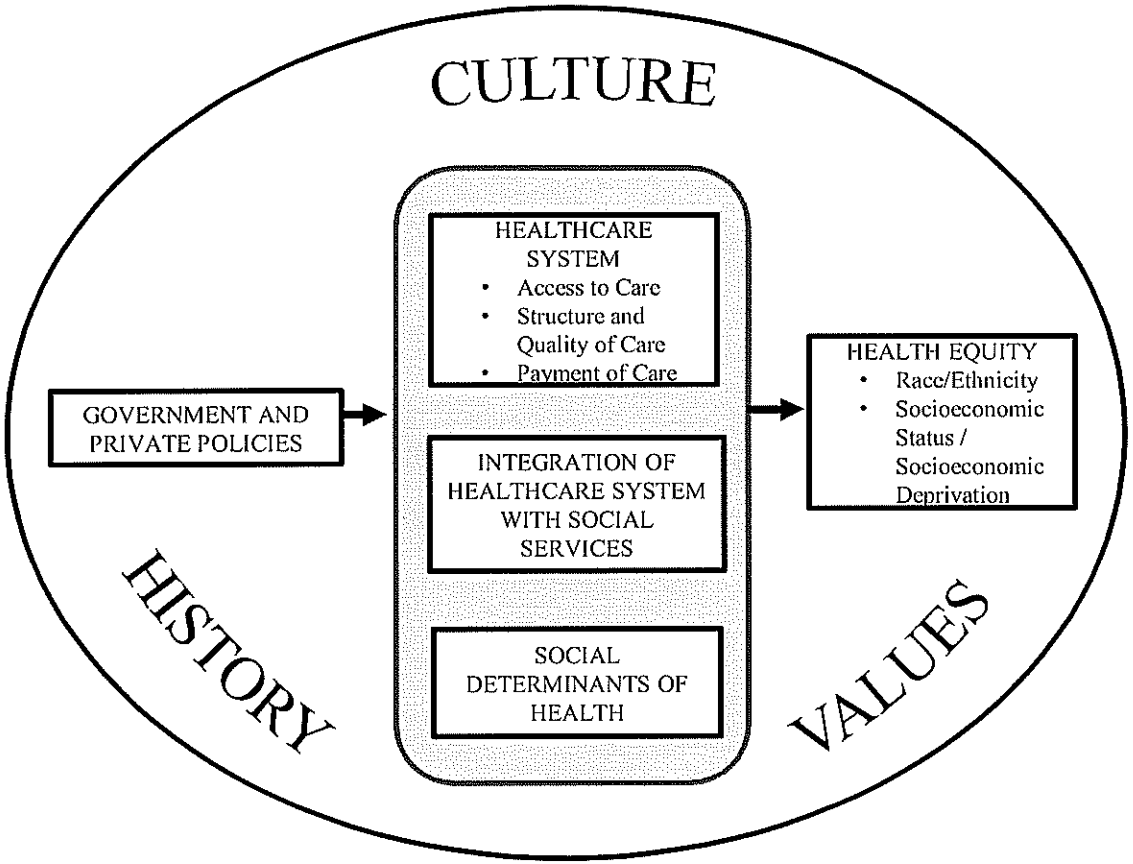

EQUALITY
EQUITY


EQUALITY
EQUITY
REALITY




# Liberation

# Conceptual Framework – Cut #1



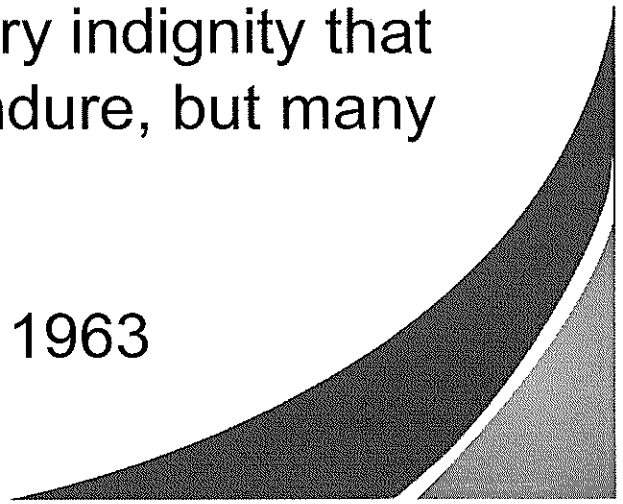

Chin MH, King PT, Jones RG, Jones B, Ameratunga SN, Muramatsu N, Derrett S. Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. Under review.

# History: Treaty of Waitangi 1840

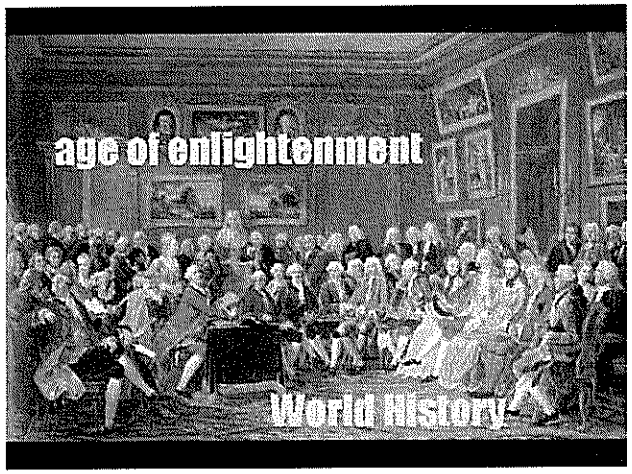
# History: Civil Rights Act of 1964

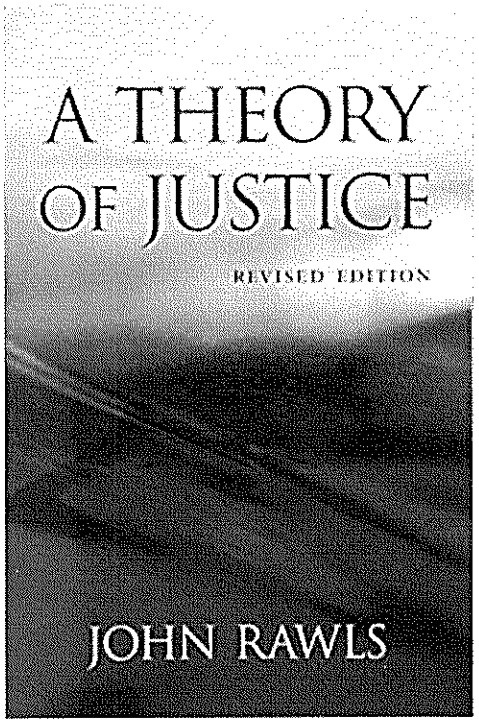
- "We are confronted primarily with a moral issue. It is as old as the scriptures and is as clear as the American Constitution. The heart of the question is whether all Americans are to be afforded equal rights and equal opportunities, whether we are going to treat our fellow Americans as we want to be treated." Discussing the right of African Americans to be served in a public restaurant, he declared "This seems to me to be an elementary right. Its denial is an arbitrary indignity that no American in 1963 should have to endure, but many do."

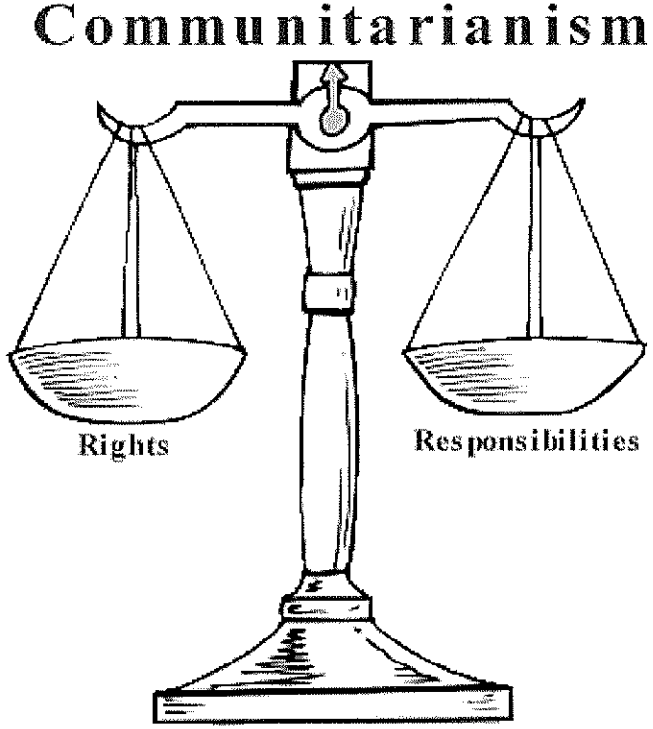
- President John F. Kennedy, 1963



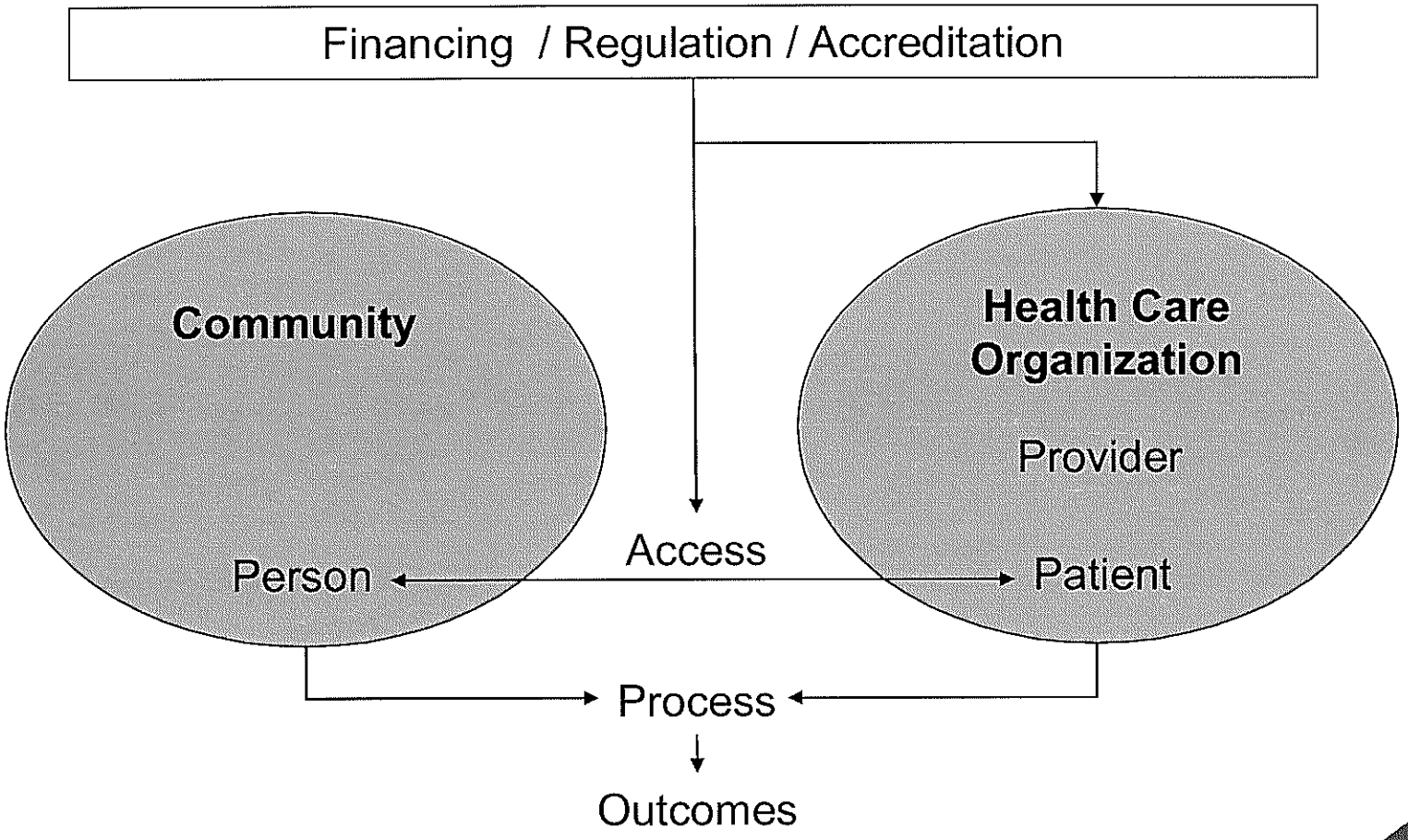
# Culture and Values: Liberalism, Communitarianism, Distributive Justice



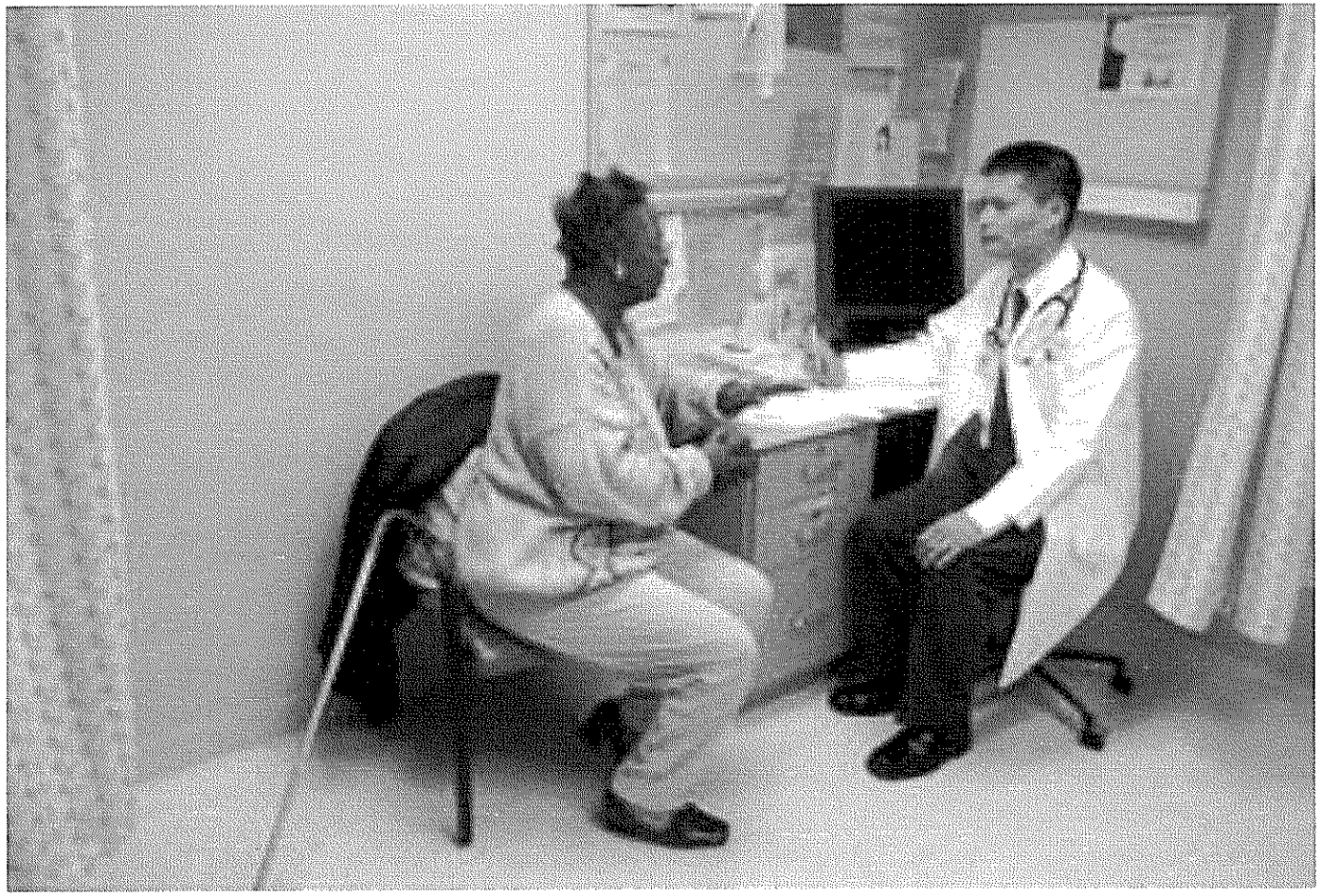



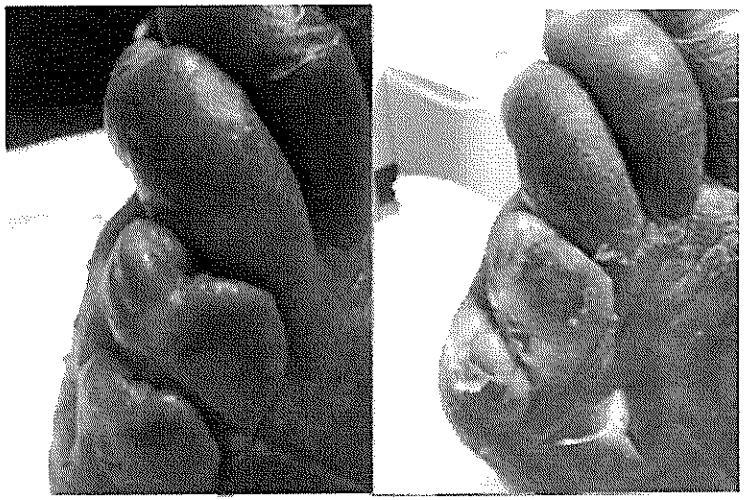
# Conceptual Framework Cut #2 – Multiple Levels

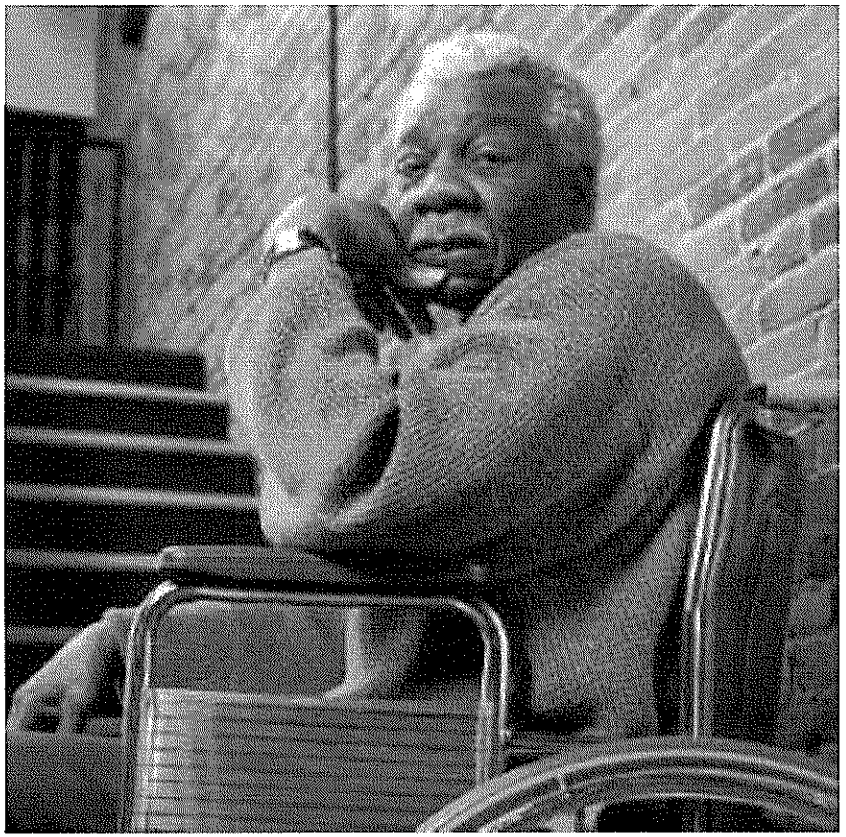


# Challenge of DM and Obesity

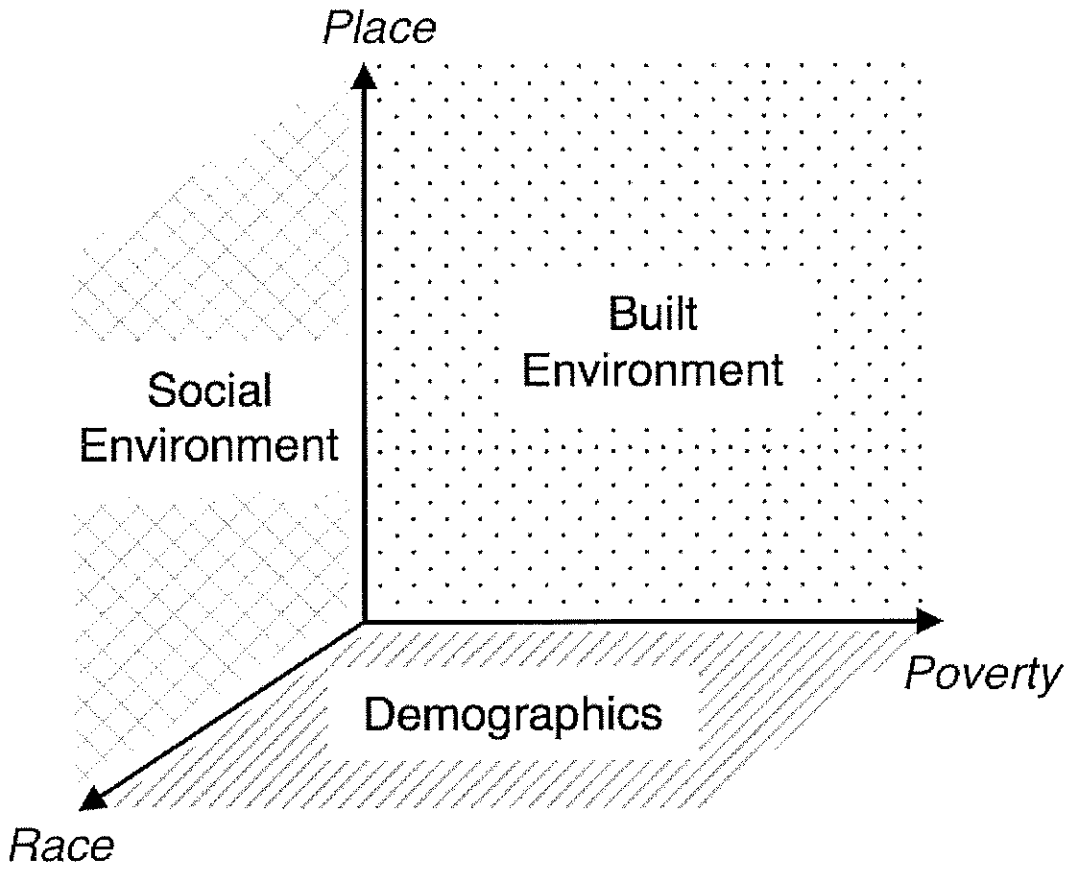


# A Diabetic Foot Ulcer





# Conceptual Framework Cut #3 – Place
# Elizabeth Tung, MD




Tung E, et al. J Urban Health 2017.

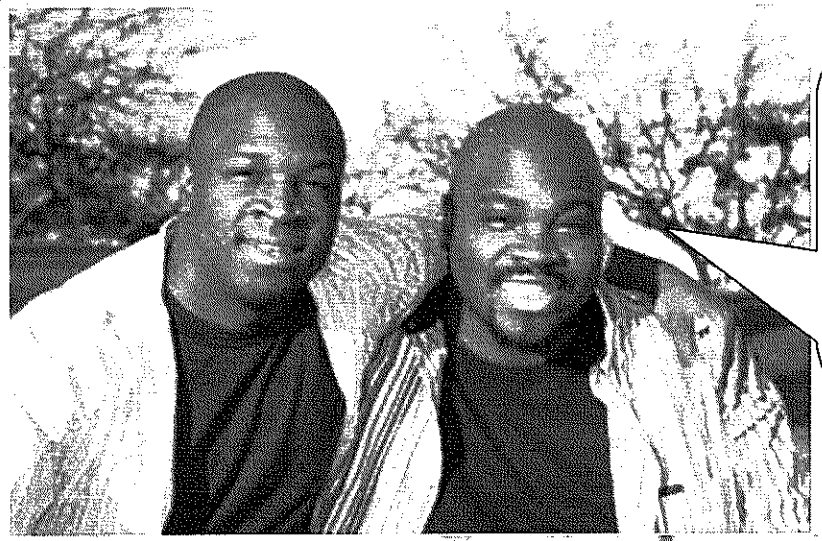
# Intersectionality

- Combination of intersecting systems of oppression that perpetuate discrimination and disadvantage based on factors such as race, class, sex, and gender identity.

Crenshaw K. University of Chicago Legal Forum 1989, p. 140.

# Shared Decision Making for Chronic Conditions:

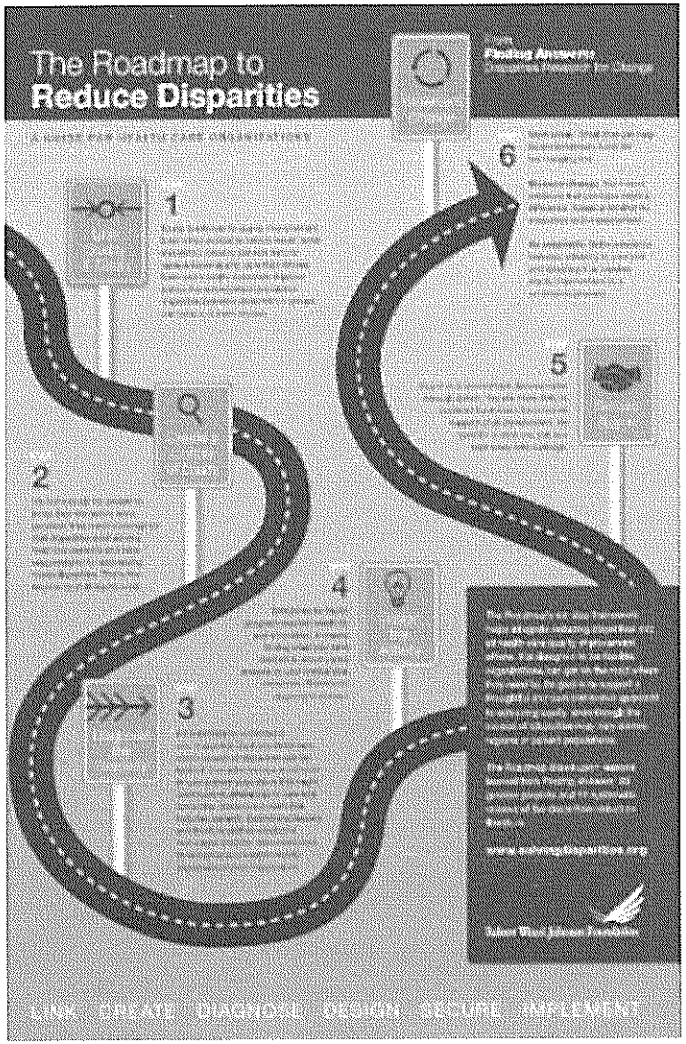
## Experiences of LGBTQ African American Patients



"When I **used to identify as a [black] male, there is this idea that I was dangerous**, right. So I'd walk in and **I had a white nurse practitioner, their body language would change.**" (Pansexual Transgender Woman)

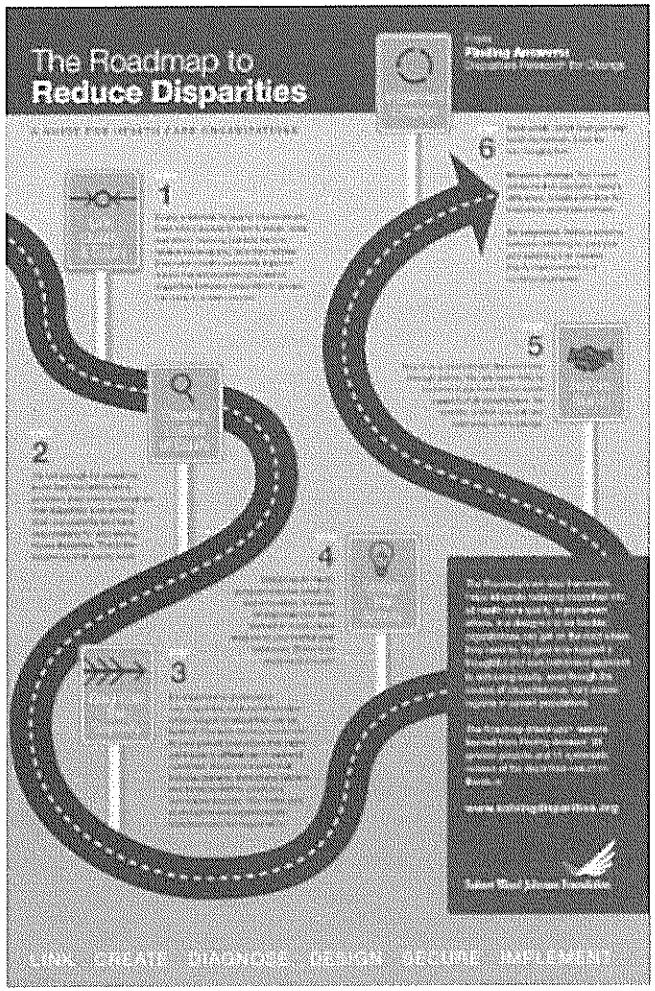
**"I don't wear an 'I am a lesbian' sign- so you don't see that. But I do wear the 'I am black' sign.** There's almost this preconception **that I am going to be somehow less of a patient.**" (Lesbian Woman)

# Conceptual Framework Cut #4 – Implementation Science and Changing Behavior



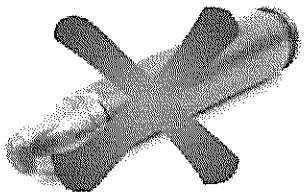
# Roadmap to Reduce Disparities

## www.solvingdisparities.org





**Chin MH, et al. JGIM 2012**

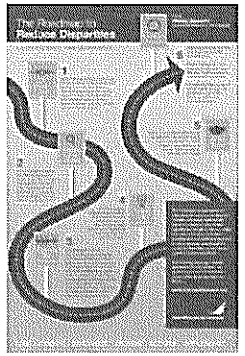


# Roadmap Principles

- No magic bullet
- Systematic process - awareness and prioritization of achieving equity, tailoring of solutions to local organizational and patient contexts, iterative QI addressing specific barriers and facilitators to change, implementation science.
- Menu of evidence-based interventions; organizations/providers like options/model

# Roadmap for Reducing Racial and Ethnic Disparities in Care

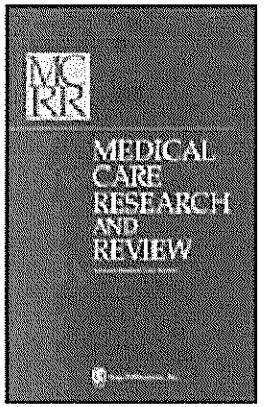
1) Recognize disparities and commit
2) Implement QI infrastructure and process
3) Make equity an integral part of quality
4) **Design intervention(s)**
5) Implement, evaluate, and adjust intervention(s)
6) Sustain intervention(s)

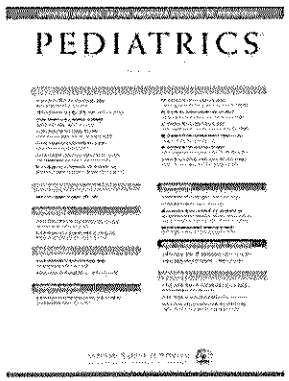


Chin MH et al. JGIM 2012; 27:992-1000

# Evidence-based Interventions

- Multifactorial attacking different levers
- Culturally tailored QI
- Team-based care
- Families and Community partners
- Community health workers
- Interactive skills-based training



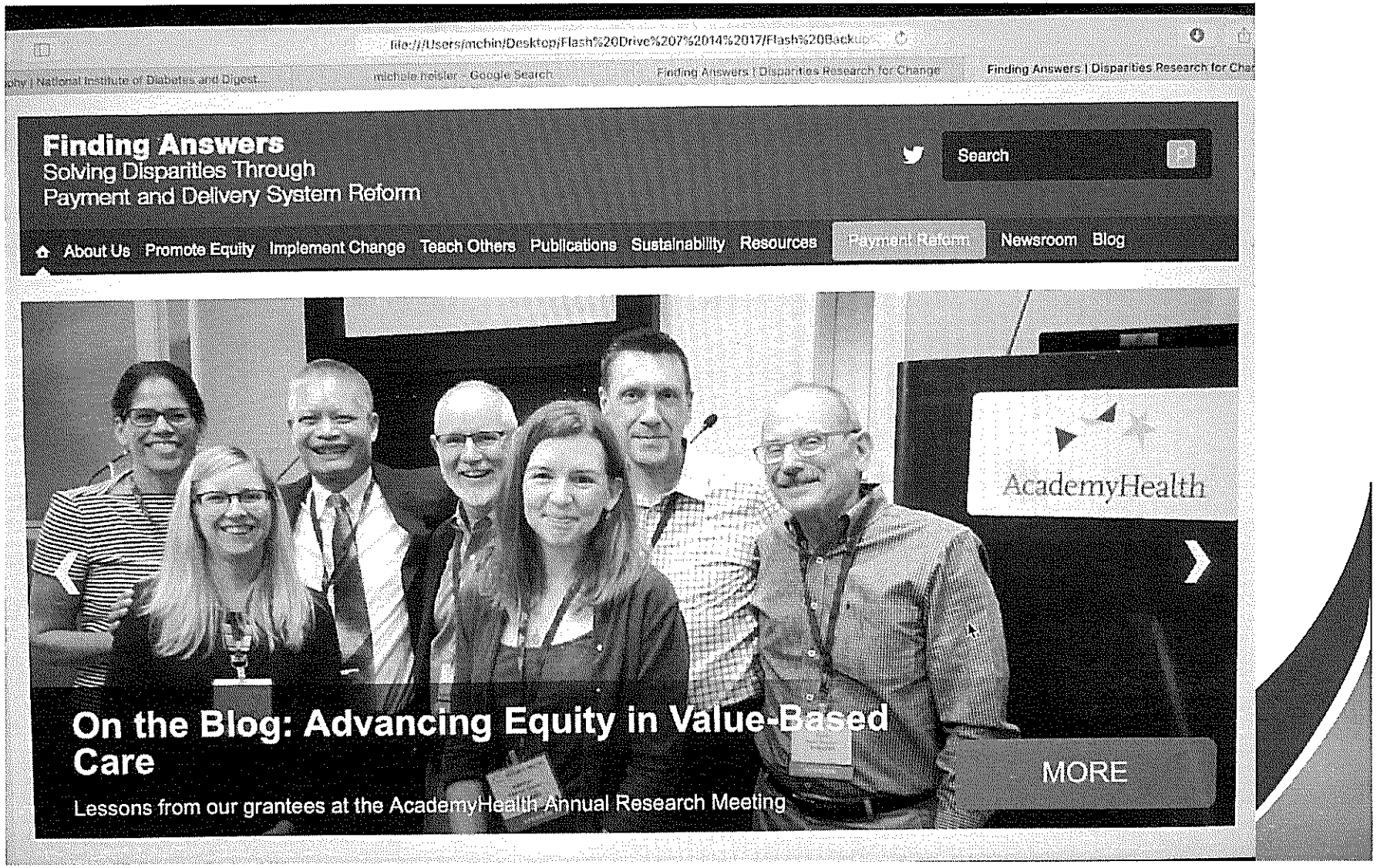

# Consolidated Framework for Implementation Research

- Intervention (relative advantage)
- Outer (external incentives)
- Inner (culture)
- Individuals (beliefs)
- Process (plan, execute, evaluate)

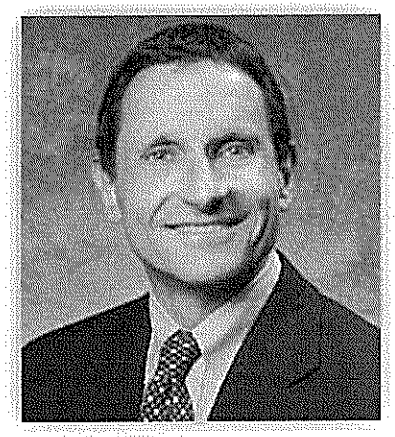
IMPLEMENTATION SCIENCE

Implement Sci 2009; 4:50.

# Conceptual Framework Cut #5 – Economic Drivers and Motivation



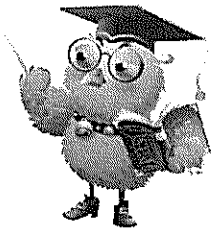
# UChicago Medicine



# Values and the Business Case for Equity

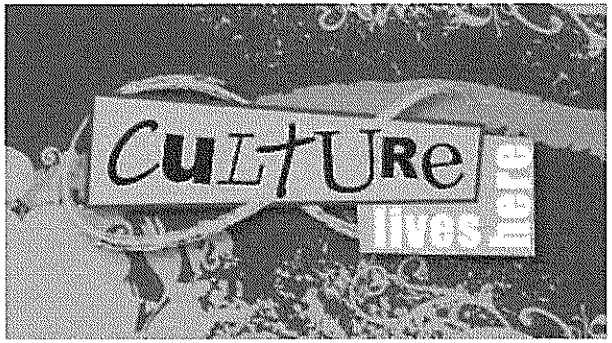
- **It's the right thing to do**
- **Business Case – Align incentives**
  - Global payments
  - Population health
  - Community needs assessment for non-profits

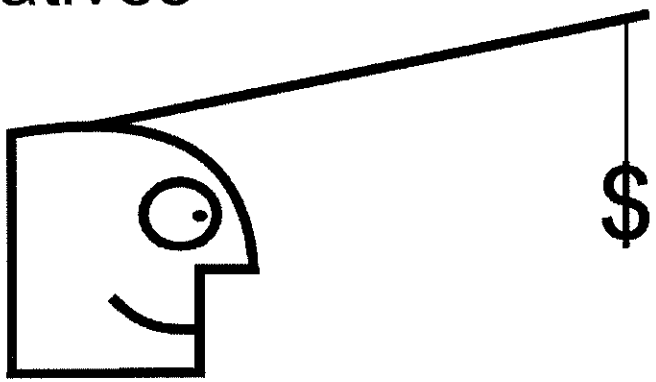
# FQHC Leadership Meetings



# Behavior Change Theory

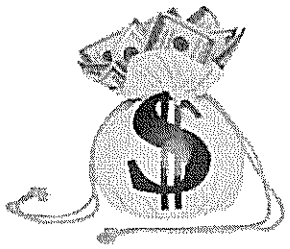
- Beliefs and knowledge
  - Why innovations are good
- Social norms
  - It's the culture / QI collaboratives
- Environmental factors
  - Incentives
- Self-efficacy
  - Coaching / QI collaboratives

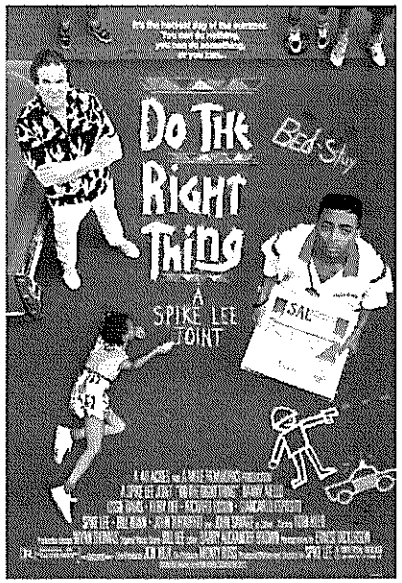


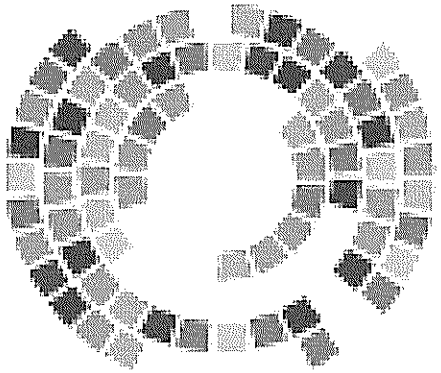




# Motivation

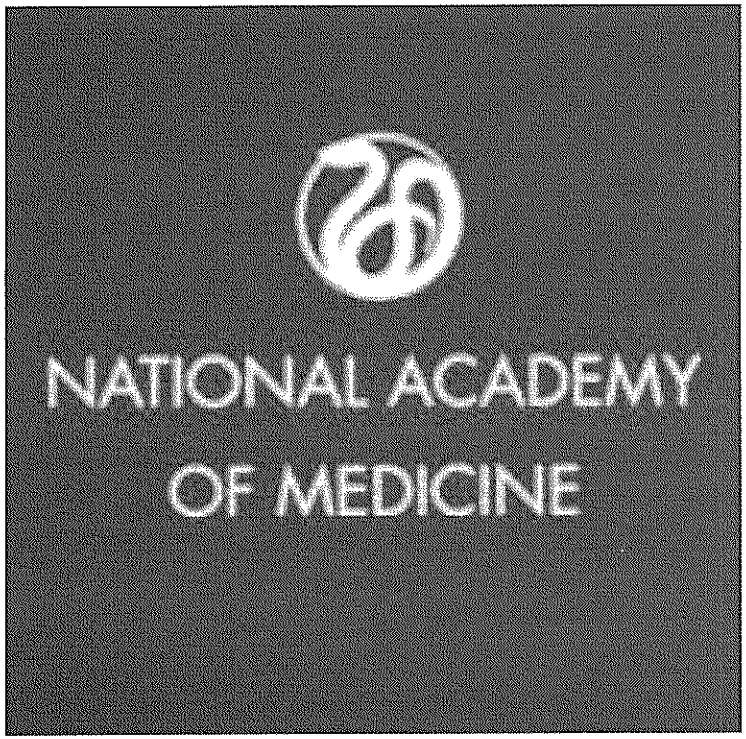
- Intrinsic
  - Professionalism
  - Do the right thing
- Extrinsic
  - Financial
  - Other rewards



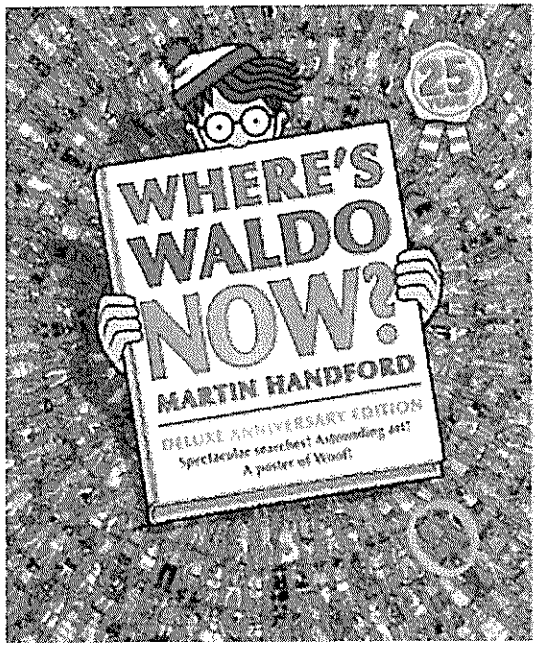


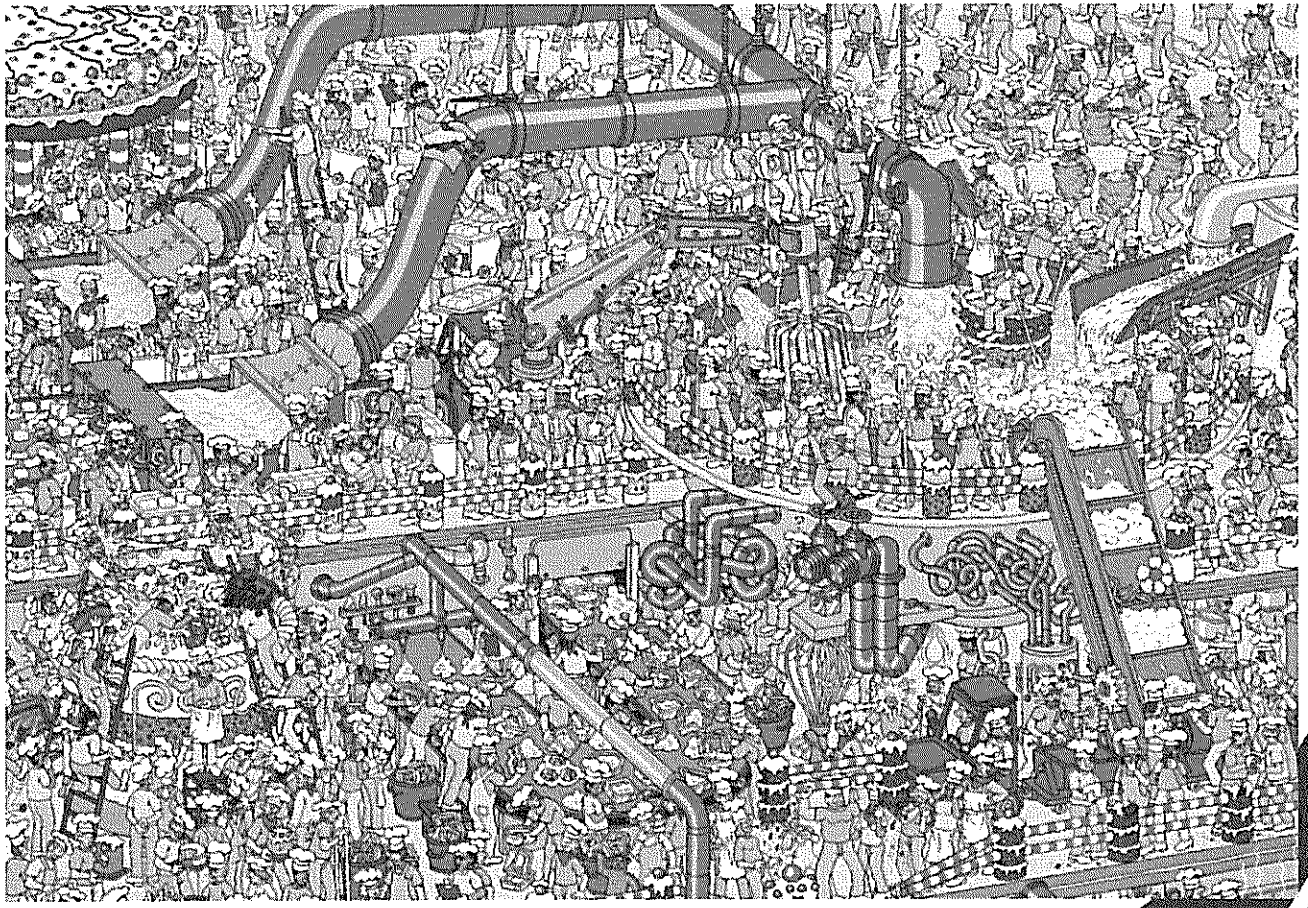


NATIONAL
QUALITY FORUM

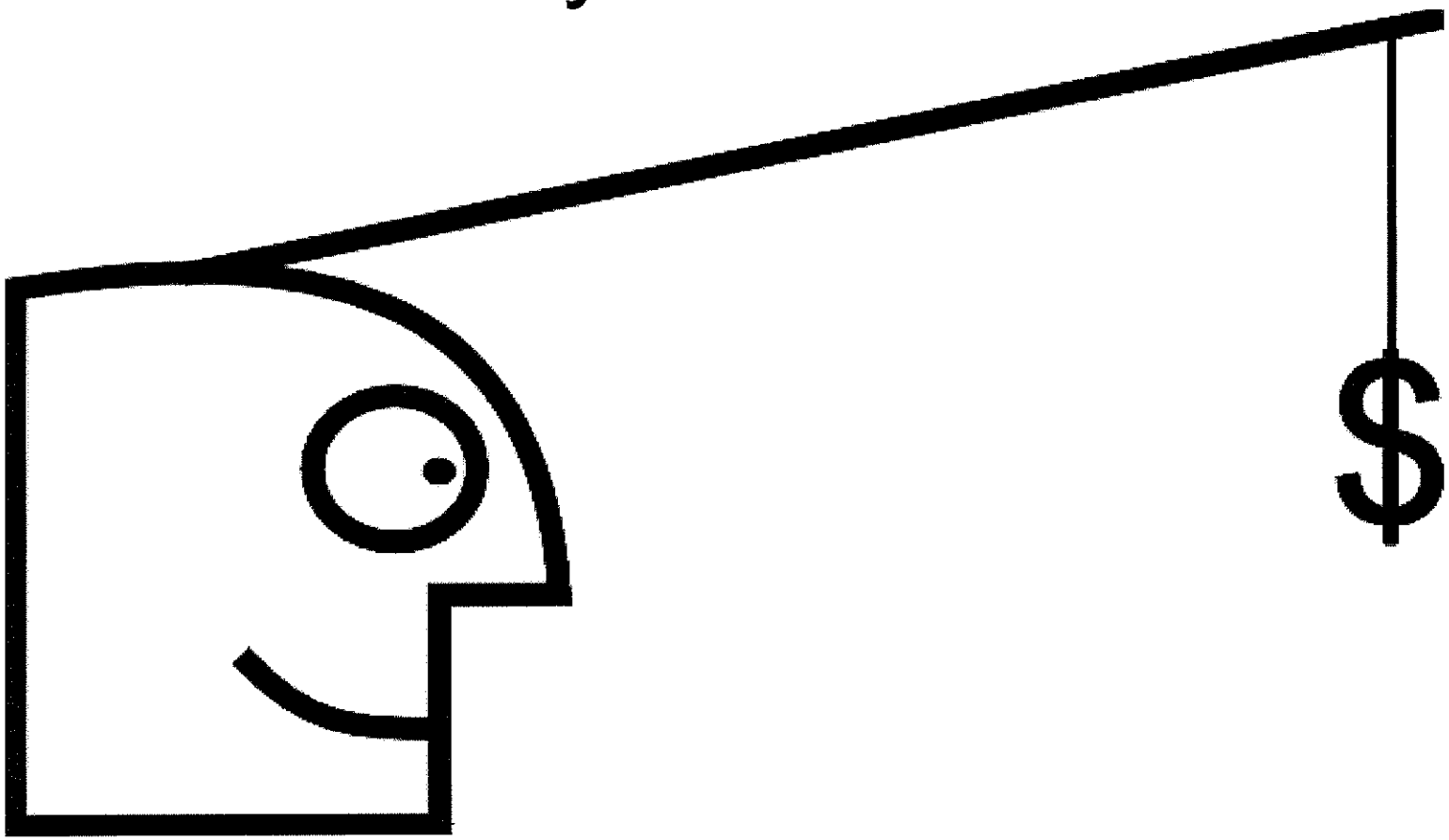



# Where's Equity?

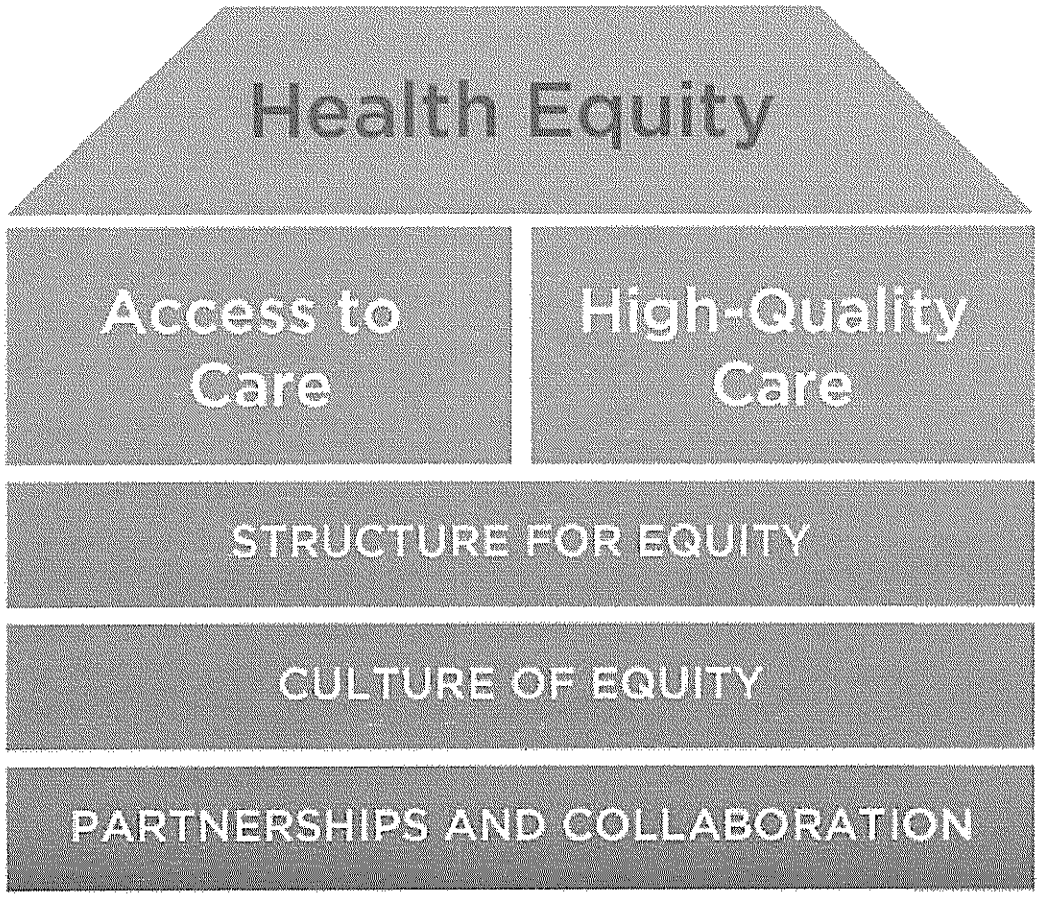


# Disparities Context: Quality of Care and Payment Policies



# National Quality Forum
# Equity Measurement Domains



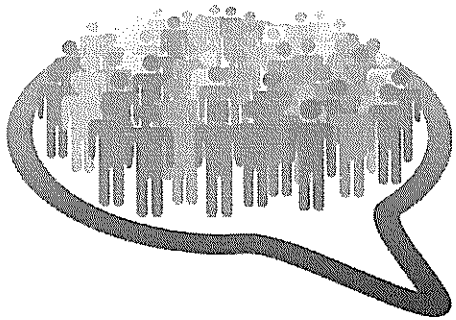
# NQF 4 I's for Health Equity

- Identify priority disparity areas
- Implement evidence-based interventions to reduce disparities
- Invest in health equity performance measures
- Incentivize the reduction of health disparities and achievement of health equity

NQF. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. September 14, 2017.

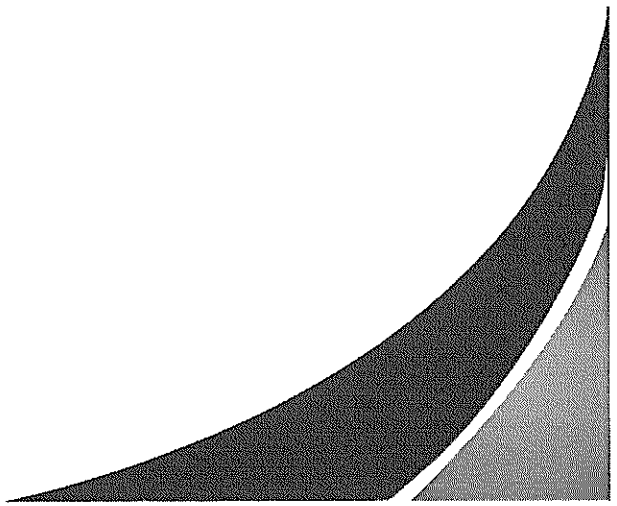
# NQF 10 Incentivize Recs

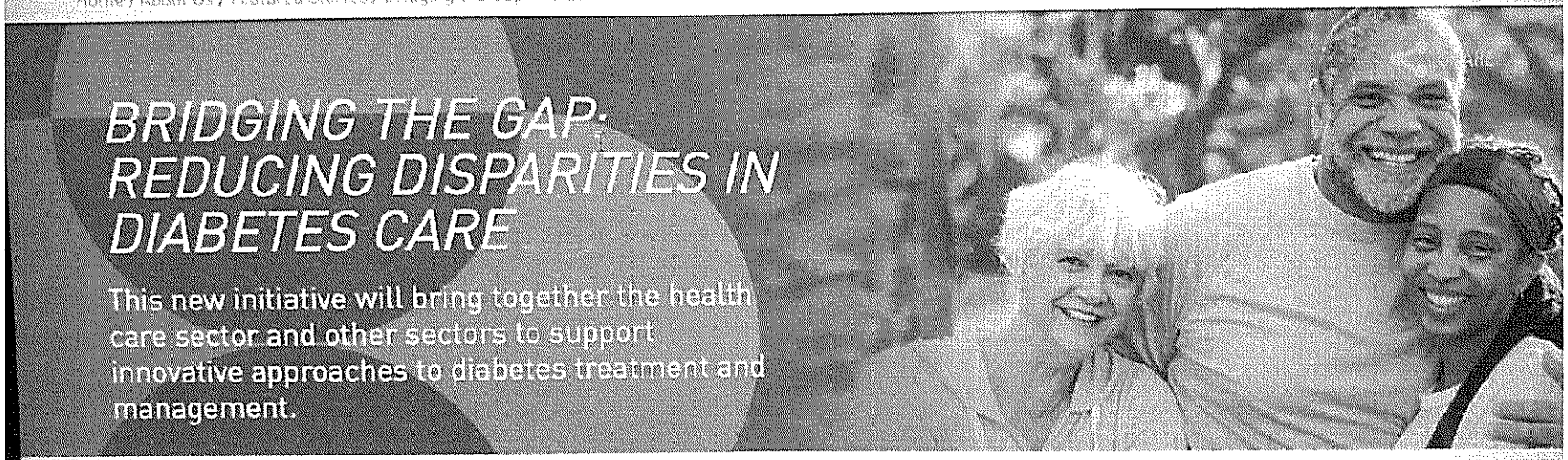
- Accountability
  - Stratified health equity outcome measures
- Redesign payment models to support health equity
  - Infrastructure – capitation
  - Specific processes - P4P
  - Integrate health and social services
- Tailor the safety net – QI and $



# NQF 10 Incentivize Recs (cont)

- Fund care delivery and payment reform demonstration projects to reduce disparities
- Assess economic impact of disparities from multiple perspectives
  - Business case
  - Societal perspective

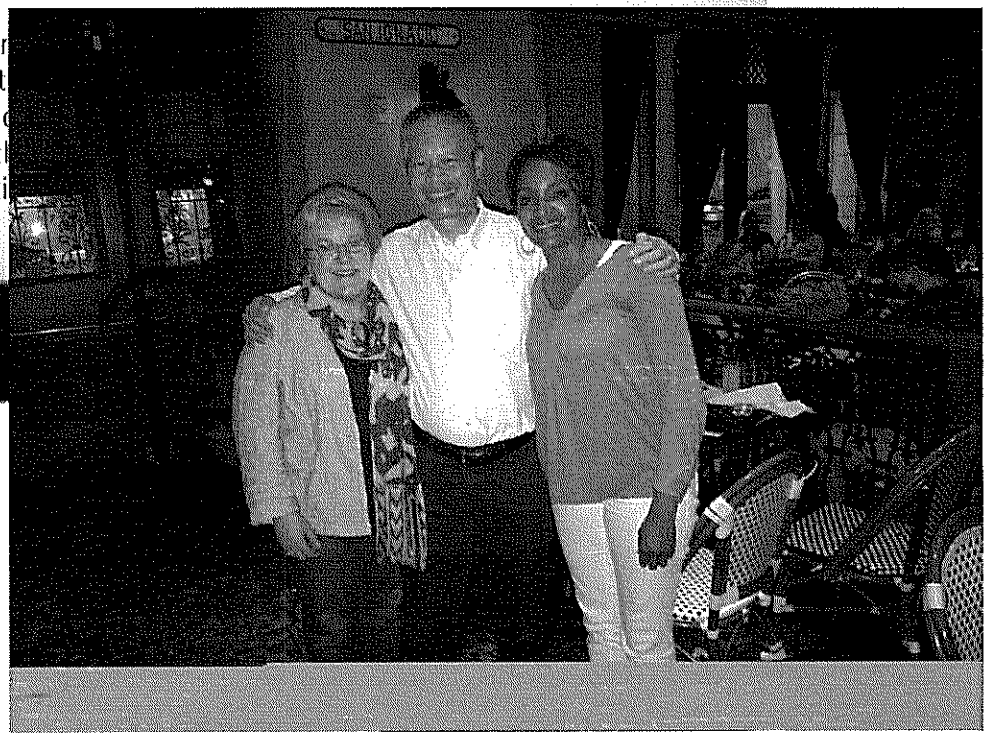




# BRIDGING THE GAP: REDUCING DISPARITIES IN DIABETES CARE

**This new initiative will bring together the health care sector and other sectors to support innovative approaches to diabetes treatment and management.**

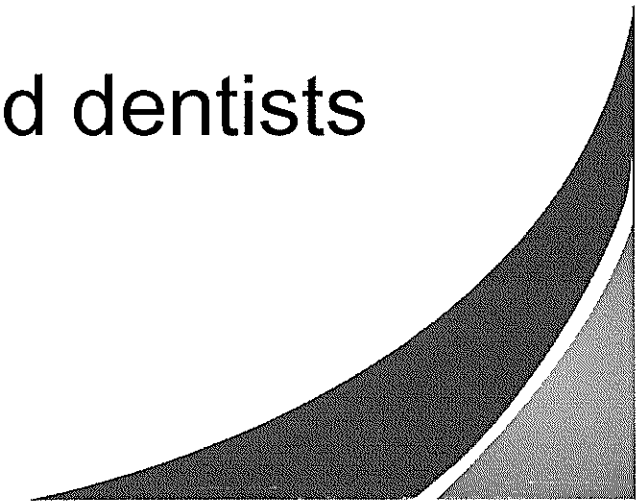
An estimated 30 million people have diabetes in the U.S., ar
underserved populations in our communities are the most
disease and its related complications. Too often, these in
effectively manage their diabetes, including addressing ot
access to healthy foods and safe opti



# RWJF Finding Answers: Solving Disparities Through Payment and Delivery System Reform

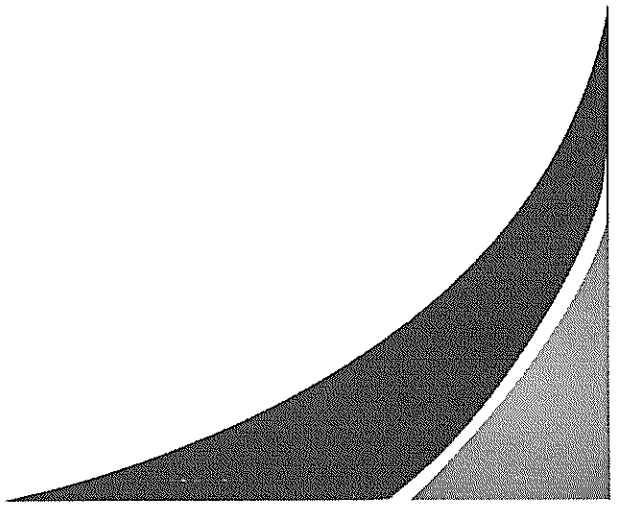
# Univ. of Washington & Advantage Dental

- Improve dental care for low-income mothers and children in Oregon
- Prevention, Low complexity: Community-based expanded practice dental hygienists
- High complexity: Office-based dentists
- Capitated, global budget
- Team-based P4P



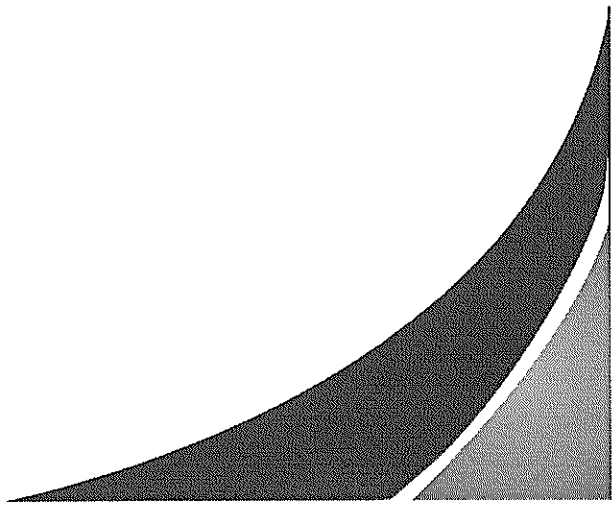
# George Mason & Fairfax County

- DM, HTN, cervical cancer disparities – 3 public clinics
- Population health mgtmt; Care mgtmt
- Capitated, global budget
- Team-based incentive
  - RVU productivity
  - Processes of care



# Mount Sinai, NYC

- Timely postpartum care for at-risk mothers
- Social worker and care coordinator
- P4P – Ob-Gyns

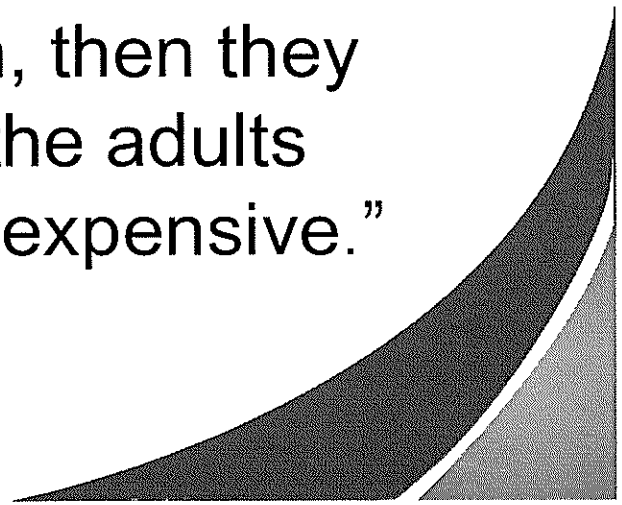


# Organizational Motivation to Reduce Disparities

- Generate evidence
- Make the **business case**
- More **efficient** care
- Disparities reduction

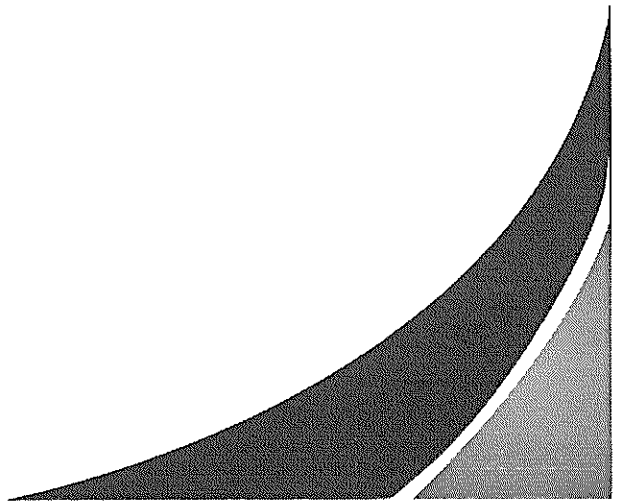
"Every dollar that you spend on a child that doesn't need any care, is a dollar you're taking away from someplace else. And the company in particular because it uses this global budgeting approach is concerned about caring for adults because Oregon has an adult benefit on their Medicaid. And so if they can be more economical about the way they care for children, then they will have more money to spend on the adults because the adults are by far more expensive."

-Project Leadership



# Non-financial Motivation to Reduce Disparities

- Aligns with **personal and professional identity**
- Improve care processes and patient outcomes

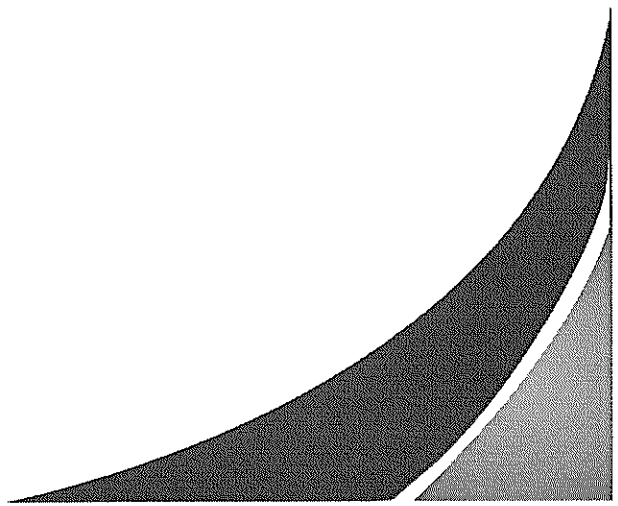


"So I think that's probably been the biggest gain I have gotten out of this. I mean, that incentive is great and all, but it is really – it's being able to transform the care that we deliver in these clinics."

- Health Care Org, Senior Manager

# Benefits of Individual and Team-based Financial Incentives

- Engages staff across roles
- **Collective goal**
- **Routinizes** behavior change

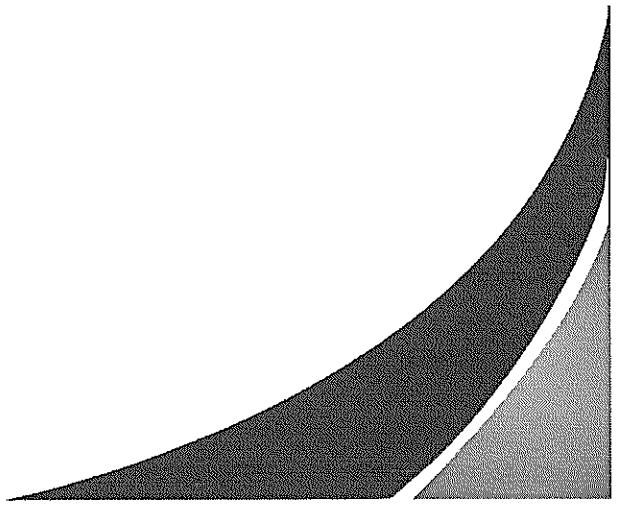


"I think when incentives came in and they identified certain key points that we need to look at and give that holistic care, then it became a standard. And so everybody is doing the same thing, not just this provider over here. All three sites are doing the exact same thing. So it's now standardized."

- Nurse Clinic Manager

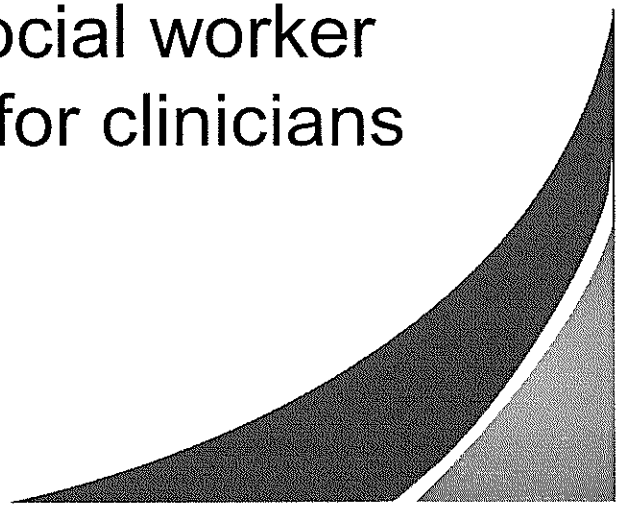
# Challenges of Individual and Team-based Financial Incentives

- Financial incentives may not prompt care delivery changes in all settings
- **Other resources may offer more tangible benefits**



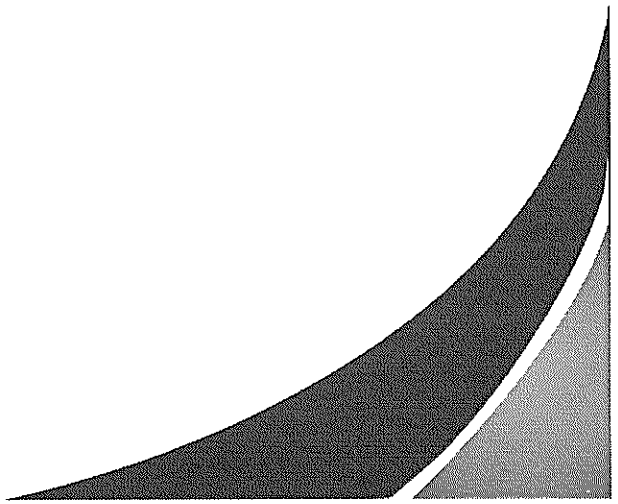
"A lot of clinicians do things because it's the right thing to do especially if people make it easy for them to do it. So it's not about the financial incentive, it's about the non-financial incentive.... the struggle in clinical medicine is that we often don't have the resources we need to take the best care of our patients. And so I thought the primary part of this study that was going to be most impactful was this extra resource [social worker and navigator] and making it easier for clinicians to do the right thing."

- Project Leadership



# Implementation Facilitators

- Buy-in and leadership support
- Align with organizational priorities
- **Data tell a compelling story** about previously unknown disparities
- Staff engagement



"I think everybody was sort of like me. "Oh we don't treat people differently or we don't have any disparities between our populations. And then lo and behold the data show that we do....So I don't know that we've changed our behaviors yet in addressing disparities, but I think we're moving in that direction because we started the discussions around what is the real root cause of why there are disparities and what can we do to change this."

- Payer, Design/Implementation Team

# Implementation Challenges

- **Linking incentives to individuals in health care organization**
- Addressing concerns from community stakeholders
- Unexpected organizational changes impact continuity and sustainability
- Information technology (IT) support for accurate data tracking and reporting

"….making it meaningful to the individual providers when these incentives are paid at the practice level. Part of the system change is at the practice level, not just kind of the payer level and the policy level. And they didn't have the practices figure out how to tie those payments back to providers and how they want to organize their practices around that kind of performance incentive."

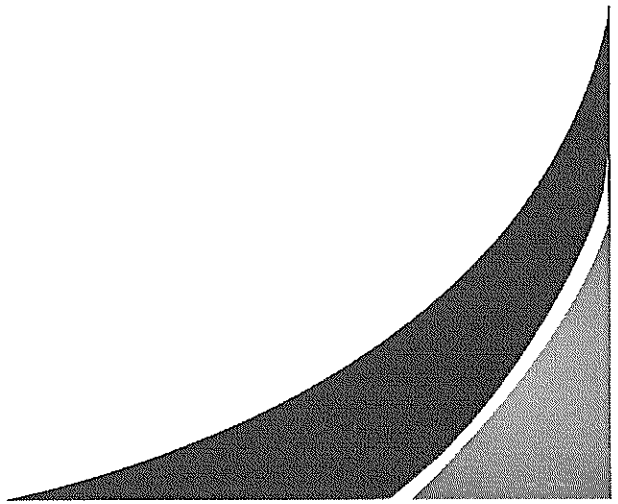
- Payer, Design/ Implementation Team

# Other State Medicaid Models for Health Equity

- Minnesota's Hennepin Health Safety-Net ACO
  - Blewett LA & Owen RA. AJPH 2015.
  - Sandberg SF, et al. Health Affairs 2014.
- Oregon Coordinated Care Organization (CCO)
  - McConnell KJ, et al. Health Affairs 2017.

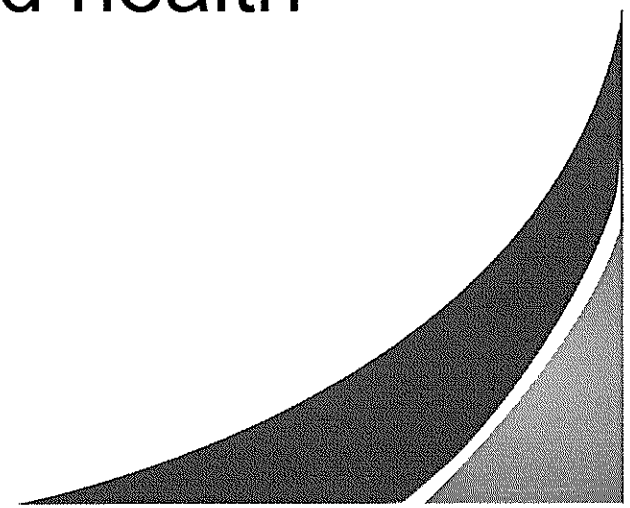
# Implications for Managed Care Contracts: Be Proactive for Equity

- Implement equity proactively as an explicit goal
  - Not de facto ignore
  - Not just examine for unintended negative consequences



# Understand Drivers

- Understand factors driving disparities
  - Social determinants
  - Place
  - Culture, values – Of society and HFS
- Understand what causes clinicians, health care organizations, and health plans to reduce disparities

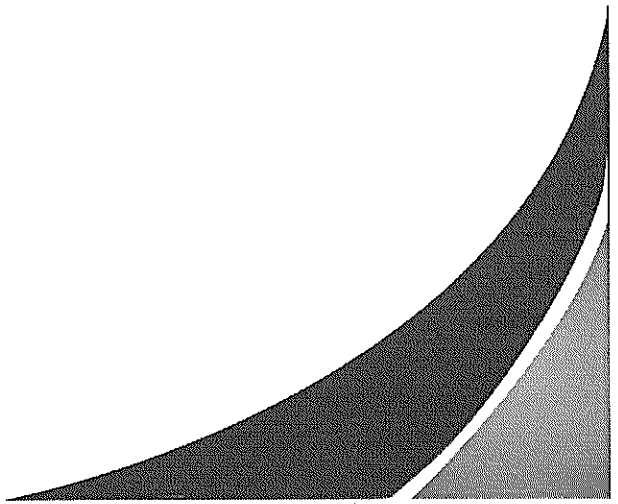


# Performance Measurement and Payment as Tools

- Understand how performance measurement and payment can be used to explicitly incentivize and support the reduction of disparities
  - Capitation - direct money towards disparities infrastructure, addressing social determinants E.g. – Teams, community health works, geomapping for challenges and assets
  - P4P – incentivize specific actions

# Tools 2

- Social risk factors
  - Risk adjustment and stratification – fairness and addressing disparities
- Performance
  - Reward improvement, attainment of threshold, reduction in disparities, combination

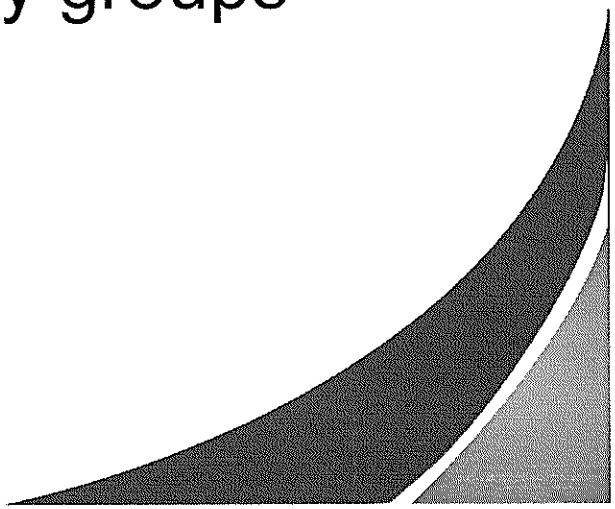


# Contract Levers

- Managed care contract levers
  - Equity as a priority – value, culture
  - Equity performance measurement and accountability – public reporting and payment
  - Use payment levers

# Partners; National Momentum

- Partner with other sectors and agencies
- Recognize momentum for using payment, performance measurement, and care transformation to reduce disparities
  - National Quality Forum
  - Patient and consumer advocacy groups - Families USA



# Immediate Takeaway Points

- Proactively design programs to explicitly advance health equity
- Consider piloting a few health equity performance measures in value-based purchasing programs
- Consider rewarding improvement, attainment of threshold, reduction in disparities, combination

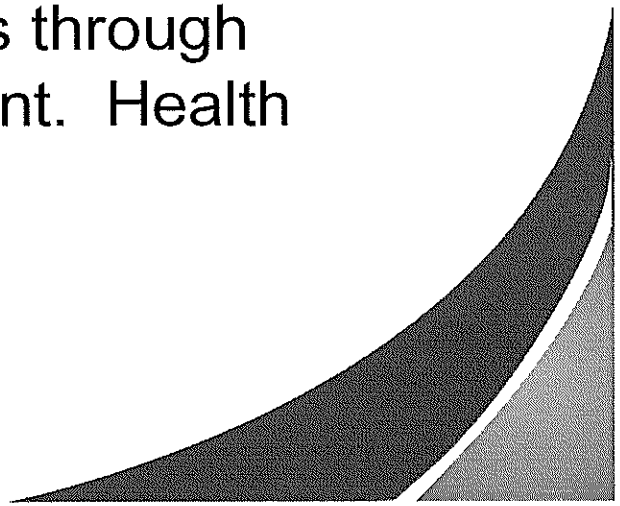
# NQF Disparities-Sensitive Measure Selection Criteria

- Prevalence and impact of condition on patients with social risk factors
- Size of the disparity
- Strength of evidence linking improvement in performance measure to improved patient outcomes
- Ease and feasibility of improvement

# NQF Hypertension Example

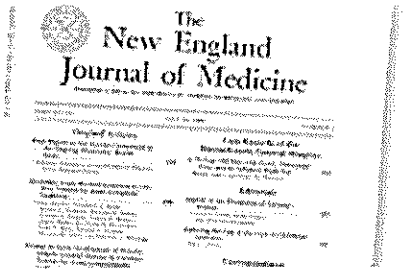
- Applies 4 disparities-sensitive measure selection criteria to HTN
- Applies 4 I's of NQF Roadmap to HTN (Identify, Implement, Invest, Incentivize)

Anderson A, O'Rourke E, Chin MH, et al. Promoting health equity and eliminating disparities through performance measurement and payment. Health Affairs 2018.



# Eliminating Health Disparities

# Leadership Matters


The New England Journal of Medicine

"Leadership matters. It is our professional responsibility as clinicians, administrators, and policymakers to improve the way we deliver care to diverse patients. We can do better."

Chin MH. NEJM 2014.