Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
September 13, 2011

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

Members Present
Edward Pont, M.D., Illinois Chapter AAP
Kelly Carter, IPHCA
Ann Clancy, CCOHF *via telephone*
Art Jones, M.D., LCHC *via telephone*
Kathy Kelly, M.D., for William Gorski, Swedish American Health System *via telephone*
Vince Keenan, IAFP *via telephone*
Margaret Kirkegaard, M.D., IHC, AHS
Diana Knaebe, Heritage BHC
Jerry Kruse, M.D., M.S.H.P., SIU SOM

HFS Staff
Julie Hamos
Jim Parker
Jacqui Ellinger
Robyn Nardone
Mike Koetting
Michelle Maher
Pam Bunch
Susan Greene
Laura Ray
Mike Jones
Lora McCurdy
Gwen Smith
Ann Lattig
James Monk

Members Absent
Kathy Chan, IMCHC
Mike O'Donnell, ECLAAA, Inc.
Indru Punwani, D.D.S., M.S.D., Dept of Pediatric Dentistry
Janet Stover, IARF

Interested Parties
Andrea Bennett, GPSI – HFS
Marlene Blackwell, Concepdus
John Bullard, Amgen
Mary Capetillo, Lilly
Gary Fitzgerald, Harmony Health Plan
Pat Gallagher, ISMS
Susan Gordon, CMH
Barbara Hay, FHN
Marvin Hazelwood, Consultant
Tim Hennessy, Consultant
George Hovanec, Consultant
Cheryl Jansen, Equip for Equality
Thomas Jerkovitz, DSCC
Kiernan Keating, Takeda
Katy Kelleghan, Heartland Health Outreach
Andrea Kovach, Shriver
Keith Kudla, FHN
Michael Lafond, Abbott
Azmina Lakhani, SGA
Philippe Largent, L65
Susan Melczer, MCHC
Diane Montanez, Alivio Medical Center
John Peller, AFC
Steve Perlin, IHA
Roberta Rakove, Sinai Health System
Cherryl Ramirez, ACMHAI
Scott Sarran, BCBS IL
Ben Schoen, Meridian Health Plan
Maria Shabanova, Maximus
Jo Ann Spoor, IHA
Cyrus Winnett, IARF
Brenda Wolf, La Rabida hospital
Scott Allen, Illinois Chapter, American Academy of Pediatrics

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I. Call to Order

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

II. Introductions

Participants in Chicago and Springfield introduced themselves.

III. Review of July 19, 2011 meeting minutes

The minutes were approved.

IV. Update on Innovations Project

Director Hamos stated that the department is moving forward with the Innovations Project to encourage and solicit a wide range of innovative care coordination models and test the community capacity and interest in providing care coordination. HFS plans to go public with a first, broad outline of the Innovations Project design on October 13, 2011, at 10:00 a.m. at the JRTC auditorium. This will be an opportunity to ask questions, get feedback and help the department think more deeply as the project moves forward.

HFS is working with the foundation community to assist in moving Medicaid data to a platform which can be made available to interested bidders. There is a request for information for potential vendors to work with the foundation community to design Medicaid data reports for interested parties. HFS is also looking at the possibility of using federal funding opportunities to integrate into the Innovations project. The department hopes to have the awards for the Innovations Project by next July.

V. Presentation on Care Coordination Care - Dr. Scott Sarran, VP and Chief Medical Officer at Blue Cross Blue Shield of Illinois (BCBS)

Dr. Sarran began with remarks on the challenges and opportunities for Illinois in light of implementation of the Affordable Care Act. Both private and public sectors are charged with improving the health of residents and reducing disparities, controlling costs and improving the affordability, quality and effectiveness of healthcare in a collaborative fashion. The BCBS goal continues to be on behalf of plan members and employer groups to optimize health care resources by increasing the efficiency of health care delivery, improving outcomes and increasing member and patient satisfaction. BCBS aligns provider payments more closely with the needs of patients and incenting providers to achieve desired healthcare and quality and safety outcomes. The state would be best served by leveraging the existing resources to partner with Medicaid managed care plans by a contracting process that ensures the desired outcomes at a time when the state has limited resources and many priorities.

BCBS has had HMO capitated models for over 20 years and currently has over 800,000 members in 80 provider groups. Member satisfaction in the HMO product, which has a defined network and some limitations on how members can access care outside that tight network, has been at, or slightly better than, our PPO product. The HMO product costs are much lower compared to the PPO product cost. The common denominator in the satisfaction being so high and the costs lower is the way BCBS sets the HMO product to work collaboratively with providers.

What has worked well is the year by year iterative process we go through with our provider groups in our HMO products. These are organized physician groups that may be medical groups, physician hospital organizations or independent practice associations. We review the performance of organized physician entities on quality, safety, service and efficiency dimensions and set targets for improvements each year. We raise the bar and do that via a variety of program

incentives. It has been collaborative relations, aligned incentives, shared risk and accountability with providers done over the long haul.

Quality measures have essentially gone up as a result of hard work by the provider groups and by us aligning incentives, sharing data, collecting and distributing best practices. It takes fairly sophisticated data systems to collect and turnaround the data into useful measures year by year. It takes some back-up metric programs that we wrap around the medical providers. There is not an easy way to move from "0 to 60 mph" in care coordination, particularly with a population like Medicaid that has a burden of challenges like health status and access. Dr. Sarran opened up the floor for questions. Refer to Attachment 1 for a summary of the Q&As.

VI. Summary of responses to HFS Coordinated Care Discussion Paper

Dr. Pont provided the subcommittee with a summary of the responses received on the department's Coordinated Care Discussion paper.

There was a tremendous amount of support for the Primary Care Case Management (PCCM) program, even as is currently structured. The Illinois Academy of Family Physicians noted various improvements in HEDIS measures for children and adults since 2007.

Several groups noted that with the influx of new Medicaid patients expected one of the key ingredients to success will be provider acceptance of the entities that insure them. PCCM enjoys wide acceptance with about 85% of providers accepting PCCM patients into their practice. We do not want to lose these providers.

There were several comments on the exact amount of risk that should be added into the program. Some of the groups noted that at least at the beginning, minimizing downside risk would be preferable. The Primary Health Care Association noted that their members operate pretty close to the margins and putting significant dollars at risk puts their bottom lines at risk. Many groups said that down side risk has to be considered but should not be something that jars the system and causes providers to drop out.

Several groups talked about stratifying the PMPM or care coordination fee. Currently, providers get a $2 to $4 PMPM care coordination fee to cover things that can't be billed for like reaching out to patients, taking time to look over lab results and coordinating care with specialists or nurses. However, the way it is currently structured is inefficient. A PCP gets that money no matter what they do; even if they don't see a patient. Several organizations were supportive of stratifying the PMPM in a negative and positive way. Make the payment more diminutive if the patient did not require a lot of care and then perhaps significantly increasing the payment for patients who do require a significant amount of care coordination.

Dr. Kruse commented that an across-the-board PMPM care coordination fee, stratified for gender and age, paid for all patients registered in a primary care practice, is an effective way to incentivize providers to reach out to patients to improve healthcare outcomes and program costs. Then, enhanced payments are needed for patients that are high risk, high cost and more vulnerable. But, how are those patients identified - on a practice by practice basis or on a population or regional basis? Can we link public health or the governmental agency with the primary care practices to make those enhanced payments work?

Dr. Kruse stated that one of the elegant features of a population based system is that each patient must identify a primary care provider (PCP) and the provider must say they will care for these patients. So, the patient has simply identified a PCP and the provider has agreed to accept the patient for a $2- $4 monthly fee. If this arrangement diverts an emergency room visit for asthma

to the PCP office, then that is care coordination. We need to have a very broad outlook about what care coordination is.

Dr. Kruse also noted that the *Relative Value Scale Update Committee's* recommendation made to Medicare in 2009, indicated that the payment for care coordination for Medicare patients be 0.35 RVUs per member per month (PMPM). The conversion factor for RVUs is about $40, resulting in a PMPM of about $14 for Medicare patients, which is in line with the scale (based on what Canada did) provided to the subcommittee prior to the last meeting. For the younger groups, you will note a $4 to $6 per month range, which is comparable to the $6 per month payment Wisconsin pays for the care coordination, in addition to providing care for the high risk highly vulnerable patients. The $2 per month payment under the PCCM program links patients who didn't have a provider with a PCP and gives them the idea that they can get care from their PCP, instead of not getting any care or getting it in a higher cost ER or urgent care setting.

Dr Pont added that these new systems don't develop in a vacuum. This is the way we are going. We are all coming out of our individual silos and starting to think about how to care for a patient across a continuum of care rather than just giving a child one medicine in our office and the job is done.

The discussion turned to what the average panel size is under the PCCM program. Dr Kirkegaard responded that under Illinois Health Connect, out of 5,700 participating providers, there are 1,800 who have 100 patients or less. Jim Parker added that on the other end of the spectrum, there are FQHCs with over 1,000 patients and some with 1,800 or more; but the great bulk of providers ---- have under100 patients or even less than 50.

A question was asked about whether or not the PCCM program only covered the TANF population, or were there participants who required complex care coordination. Dr Kirkegaard indicated that the PCCM group includes both TANF and AABD enrollees, with the exception of dual-eligible clients and children on SSI. Another participant stated that the care coordination strategy laid out by Director Hamos would be inclusive of the more complex populations, as they account for a significant amount of cost the department faces. That may or may not be very different than the population under PCCM and that may or may not be how the acceptance of risk is thought of over time. There are a lot of pieces in motion here. The complex population may be outside of PCCM now, but not outside the Innovations project and care coordination discussion.

It was asked if there is data showing that the PCCM program, as currently structured, has resulted in savings and if more money was put into the program would there be more savings. Or, put another way; has the payment of the case management fee caused a change in provider behavior?

Dr. Kirkegaard responded that through FY2010, a savings of about $430 million is attributed to the PCCM program. This savings is based on internally generated numbers by HFS. The Robert Graham Center which is doing the policy study for the American Academy of Family Physicians currently has a grant through the Commonwealth fund to look at that data more rigorously for savings and clinical outcomes. This would provide external verifiable outcomes. The HFS internal analysis takes out the AABD population of about 100,000 patients because those patients were under co-management at the same time through Your Healthcare Plus (YHP). There are additional savings attributable to YHP, but it isn't possible to tease out the savings attributable to PCCM or case management under YHP.

From our anecdotal experience, the payment of the case management fee does cause a change in provider behavior. Practices are at various levels and most of the Medicaid practices are under-resourced and in very poor neighborhoods. They tend not to belong to very large infrastructures. But, they do indeed pay a nurse to come in on a Saturday morning to call participants to remind

them their child is due for an immunization, or they are due for a mammography. And, if they don't AHS can remind the providers that they are paid for coordinating the care of their enrollees; which is in-line with Dr. Sarran talked about in the need to address where the provider is now and moving the bar up.

Dr. Pont noted that the cost savings combined for both programs approaches $1 billion. There are also studies from North Carolina that has a similar PCCM program, which show a decrease in PMPM costs even when the average patient acuity had gone up.

Dr. Pont continued his summary of the comments received on the department's white paper, indicating that there was a fair amount of concern about the seamlessness between the insurance exchanges under the federal reform, Medicaid, and the care coordination entities. The Illinois Chamber of Commerce was concerned about "market churn", where patients go from provider to provider and don't really get that good quality coordinated care.

Dr. Kirkegaard stated that under PCCM, enrollees could change up to 12 times a year and there was concern that PCCM would not meet the goal of continuity of care of management in a medical home environment. AHS found that patients do not often change their medical home. The study by UIC showed that patients in the Medicaid environment actually understand the concept of medical home better than commercially insured patients. When conducting the PCCM client survey, it was found that clients know where and have been to their medical home and by and large do not change their medical home. Overall, clients value their medical home.

Dr Jones stated that his clinic works with Blue Cross Blue Shield and they do not set up a PCCM program. For quality and safety, we should look to them as we structure our coordinated care program.

Dr Kruse referred to the Community Care Program in North Carolina. It is similar to Illinois' PCCM program except that instead of a private company like McKesson working with the high-risk, high-cost patients, they did it internally in the state. They engaged community steering committees, mostly with county health departments to link with primary care practices to do that part of the program. They had some incredibly successful improvements in health outcomes and declines in costs. Their website includes external audits that show the dollar amounts saved. It is on the order of, or higher than, those savings seen in Illinois. So that type of program really does work, as the program at Blue Cross Blue Shield does as well. We have to understand that these types of state-wide programs are very effective for both cost and health outcomes.

Dr. Pont noted that in the white paper responses there was support for the NCQA HEDIS measurements. No one felt the need to "reinvent the wheel" and come up with new measures. There was also a lot of support for "pay for performance". Groups were saying it was far too small and should be more robust. This gets to the care coordination fee discussion that, especially with small number of patients, there really needs to be strong financial incentives to get things moving.

It was noted that it is difficult to get a child to a specialist as things stand now. This is even true with all the specialists under the same plan where the specialist is provided with a written referral. If we are talking about going to a model like Pennsylvania has, how do we guarantee access to specialty care? Ms. Gordon agreed that access to specialty care for children is a grave concern that needs to be addressed.

Keith Kudla stated that FHN must contract voluntarily with specialists. It is not like the Illinois Health Connect PCCM. FHN has expanded the number of contracted specialists by 15% and expects to expand by 30% by the end of the year. In terms of higher end specialty, tertiary care, FHN has Sinai hospital, Cook County hospital and Rush University Medical Center in their

network and ready to add another tertiary medical center. Some medical centers will do single patient agreements. FHN does have to pay more than the Medicaid fee schedules as required under their contract with the state to provide the care that members need. If the care is not available in the FHN network, we will go to the place that has that care. It is a challenge but it can be done. We have been doing it for 15 years now, but it costs more.

Ben Schoen, Meridian Health Plan stated these are cogent points. The onus falls on the MCO to coordinate care and to reach out and be the concierge service for that PCP and the member to make sure they get the services needed. It means at times going outside the closed network and operating as a point of service. It is beneficial for not only the provider but the member seeking care. It is doable even if you have many providers and not an administrative burden for them.

Gary Fitzgerald stated it is the same for Harmony Health Plan that has 2,800 specialists and thinks they are doing pretty well with that enrollment. If we need to go outside the network, we do as it is mandated by contract to provide services.

VII. Solicitation of additional comments for modification to PCCM

Dr. Pont asked if anyone had additional comments on the PCCM grid prepared for the Care Coordination Subcommittee.

Kelly Carter stated she agrees with Dr. Kruse that the part about diminution of the care coordination fee doesn't fit well for all provider settings. Dr Kruse added that the rest of it looks great. Dr. Pont advised that he could change the word to modification and make it clear that the subcommittee doesn't want the fee to go down. This allows for Dr. Kruse's suggestion for stratification of the fee.

Ms. Carter stated that she was also concerned with the same statement that includes "… for patients who do not receive comprehensive care." She indicated that there should be a simple transparent definition for not receiving comprehensive care. It is hard to leave the statement in there as it is not realistic. A provider should not lose money if a patient doesn't come in once a year. Dr. Pont responded that HFS is not likely to limit the definition to only PCCM and have another definition for other care coordination entities. He would like to keep the language a little vague, but will try to revise it to address Ms. Carter's concern.

Dr. Pont will send the revised PCCM Improvement grid to Ms. Lattig for her to distribute to the MAC prior to their meeting on Friday, September 16th.

VIII. Open to Committee

An explanation on the internal time frames or deadlines for HFS prior to 2015 was requested. Jim Parker stated there are at least 3 different time frames for the Care Coordination Innovations Project. Phase 1 of the Innovations time frame where we would get the solicitation out by the end of the year and have proposals submitted in about 4 to 5 months. The contract with Automated Health Systems (AHS) as the PCP administrator expires on June 30, 2012, with no renewal options. HFS will need to issue an RFP for this contact early in 2012. For the PCCM program in particular, the timeline for designing what we want and need from the contracted administrator is sometime in the next 4 to 6 months, so input received can go into the drafting of the RFP. And, next summer there would be another solicitation process under Phase 2 of the Innovations Project, in which MCOs would come in.

It was asked if Illinois Health Connect would be considered as taking on part of that 50% coordinated care group option. Dr Pont responded that looking at PCCM enhancements to allow IHC to become part of the 50% groups is the charge of this MAC subcommittee. The Medicaid reform law says that PCCM, as it currently exists, is out as it doesn't meet the definition of a

coordinated care entity and any other entity must assume full risk or at least some other risk-based arrangement.

Clarification was requested on the target entities for the RPF to be issued in January of 2012, versus the one to be issued next summer for MCOs. Mr. Parker explained that the department is looking for a kind of grass roots up effort under which providers collaborate to provide care coordination. If there is an extra entity providing those integrative services that is fine.

IX. Next Steps

Dr. Pont asked if the subcommittee wanted to meet in November or January; recommending the subcommittee stay with the second Tuesday of the month. Mike Koetting indicated that without Director Hamos or Theresa at the meeting today, the department would need to review schedules before committing to a new meeting date.

Susan Greene reminded people of the meeting on October 13th at 10 a.m. in the JRTC auditorium when the department will share the concept for the innovations project. Ms. Greene was asked if there would be handouts available prior to the meeting. Ms. Greene indicated that the department will give a PowerPoint conceptual presentation that outlines the goals and some of the ways that the department has identified how provider groups can engage in a contract but not to expect a completely developed RFP type presentation.

X. Adjournment

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

Summary of Questions and Answers Addressed by
Dr. Scott Sarran, VP and Chief Medical Officer at Blue Cross Blue Shield of Illinois (BCBS)
September 13, 2011

1. Please provide some specific examples of some incentives that BCBS gives providers and quality measures that are given back to providers in the HMO that the providers in the PPO don't get.

We assist with data and feedback. We bring groups together to share best practices. Some of the measures are very straight forward HEDIS quality measures, e.g., diabetic control measures, blood lipid control measures, blood pressure control measures and care coordination kind of measures. Over the years, some provider groups have dropped out and some we have asked to drop out. We have learned that when the demand for improved care is great and costs are truly constrained, we don't think that every provider is capable of being an effective partner. We recognize that particularly in Medicaid we have a dearth of willing providers. We have to recognize that when we prioritize the objective measurable improvement of healthcare outcomes with constrained costs, we may not have every provider as an effective partner.

2. Are there financial incentives as part of that whole process and which financial incentives work the best?

Yes. The main principles incentives must meet are: 1) be simple and transparent so providers understand them; 2) reflect a mix of quality, safety, service and cost outcomes, rather than based solely on cost outcomes; and 3) be significant enough to the providers' underlying business, to change behavior. If it is a small amount of money relative to the total amount going to that provider, the provider isn't going to re-engineer their care processes and/or invest in new technologies. Also, if there isn't enough monetary incentive, they will not be able to afford to make the kind of changes needed.

3. Does BCBS provide risk adjustment within medical groups based on having patients needing complex care?

We do some simple risk adjusting although in our commercial products there isn't as much disparity as there would be in a government program. Risk adjustment in a government program is essential.

4. Is there a threshold that incentives must reach to be meaningful enough to cause behavior change?

An exact figure isn't available, but for most programs "pay for performance" incentives are not robust enough to cause the change in provider systems of care. It is not enough to catch the provider's attention on a patient by patient basis. You want the incentives to be high enough so the provider will change the fundamental way they design their practice or hospital to run. Ideally, the incentives must be high enough so they make investments based on achieving those incentives. It has to be a fairly substantial amount. There is also the need to be sensitive to the provider's capabilities. Some provider entities are very robust from an infrastructure and clinical technology viewpoint with the ability to invest in new programs. They can manage more risk, so a lot of the contract can be on an incentive basis. Other providers may not have the ability to invest or have the technologies or clinical programs. These providers have to be moved gently along to take more risk. There isn't an easy single model. A reason the private sector should have a role is that we're able to do some fine tuning in our provider arrangements and negotiate a contract somewhat differently from one provider to another.

5. With 80 provider groups, do the annual goals vary from practice to practice?

The goals are primarily the same. We have some individuality in setting targets group by group by balancing the need for quality for members and recognizing that all 80 groups do not have the same ability to invest in programs and infrastructure.

6. Do you rely on encounter data for much of your measurement?

Correct. We also do some actual chart abstracting, but we try to minimize that because of the burden on providers particularly if there is no electronic health record (EHR).

7. Do you have a standard file exchange program that you expect groups to adhere to?

The answer is pretty much yes, but we are sensitive to the provider's technology capability and don't want them to spend a dollar collecting data for a dollar incentive.

8. How much chart review does there need to be?

Most measures are based on encounter data. The fact that groups must submit the data to achieve incentives, gives us confidence that we are getting clean data. Some of the quality measures that are tough to get at absent an EHR can be obtained through the provider doing a chart abstraction, and we have an audit process to ensure that it is done honestly and accurately.

9. How successful have you been in encouraging providers that don't have the capability to take on risk? How do you incentivize providers who are not there yet to put in the infrastructure and personnel?

There is not a "one size fits all" answer. Particularly for Medicaid where there can be a relative dearth of providers. As a state we will want to be as inclusive as possible and do things to move providers along toward being able to successfully take on some risk and accountability. This requires some flexibility in individualizing provider arrangements by setting the bar lower for the first year and building on success. We can do some things with provider groups along the lines of some investments in resources to get them up the learning and infrastructure curve.

10. Of the 80 provider groups, how many are on a capitated basis?

All of them are on a capitated payment. The risk is split between BCBS and the group. BCHS has somewhat more than half the risk and groups have somewhat less than half. It is fairly significant.

11. Is that an essential component?

We think it is absolutely the desired outcome for both BCBS and the provider groups as it works for both. When we are in an environment like the state Medicaid program, where we all clearly want to be sensitive to the relative dearth of providers, and for some people the need to walk before we run, we need to be flexible. We believe quite strongly that predominately fee-for-services payments will not get either government programs, or the private sector, either shopping through or outside the exchange to where we need to be as a country. The fee-for-service payment arrangements are a significant part of why we are at such a crisis in health care.

We also recognize that many mistakes were made 20-25 years ago in the first attempts at capitated managed care. These were characterized by arrangements where there was a lot of risk was placed on providers that didn't have the infrastructure or ability to manage that risk; and, the risk wasn't supported by enough attention to quality measures, risk adjustment or analytics. Now we are back to moving away from fee-for-service and toward shared accountability with providers, but we have to do this with flexibility toward where providers are or are not.

12. Is that why BCBS is now moving toward risk based arrangements such as the demonstration project with Advocate Healthcare?

Correct. So even with our PPO which has traditionally been: fee-for-service, with some pay for performance on the hospital side, with a broad network with very little in the way of access restrictions for members, we are moving to shared accountability, where the providers are capable. We executed a

contract in January, 2011, with Advocate Healthcare that is similar to the CMS proposed model for an accountable-care organization (ACO).

13. Are providers motivated because they have a large group of patients?

Yes. One thing that has contributed to success is that there is enough business flowing through these arrangements for the provider to take them seriously. For a hypothetical provider group with 5 to 10 providers and 100 patients in a capitated or risk based, shared accountability or incentive based arrangement, there probably isn't enough incentive for them to change their care processes or invest in new programs. There has to be a robust amount of money flowing through these kinds of arrangements.

CMS has a clear commitment to move toward accountable-care type arrangements via a variety of structures. The discussion sets in around the synergies between the public and private sector. If Medicaid is going down a road where there is shared risk and shared accountability, and the private sector is also going down that road, the contract structures and measures do not need to be exactly the same. What the providers have to do to succeed is the same in terms of re-engineering quality, service, safety and efficiency. If these are the same that really allows the providers to make a current re-engineering of the care process. That is a powerful path for us now in terms of the private and public sector.

14. Are any of your current providers FQHCs?

Yes.

15. Do you know what the aggregate payout was for incentives in 2010 for providers?

There are a couple of ways we can define that. A lot of the pay-for-performance is built into the monthly capitation fee. There is shared risk on quality, safety and efficiency.

16. If you have a provider with patients in both a capitated plan with quality measures to award specific outcomes and in a traditional fee-for-service plan with payment based on the procedure codes, do you think the providers practice differently?

Our experience is on some levels they practice the same but in most groups there is significant additional investment in the care of the members for whom the provider is accountable. When we are specifically paying for proof of diabetic outcomes it creates outreach to members who have not come in.

17. Do you see a difference in ER or hospital utilization for patients in an HMO versus in a PPO?

Overall there is higher quality and lower utilization for the HMO patient. In reality the provider wants to do the right thing but fee-for service doesn't necessarily pay for doing the right thing and the provider doesn't have the luxury of doing things that are not paid for.

18. Adjusting for risk factors, how much cheaper is HMO Illinois that the PPO product?

Without quoting exact numbers, the cost difference is significant and the HMO is lower in terms of medical cost.

19. How much of those differences are there due to the providers in the HMO versus the PPO provider pool?

These are not separate pools. There is about a two-thirds overlap in the PPO providers that also work with one of the HMO products. Many of the specialists in hospitals are in one of the HMOs. Differences are probably both the provider pool and the HMO requirements. When the imperative is to manage with fewer resources and yet to improve quality in service, I don't think all those providers will make that cut. That said we can bring most providers along if we do it in a flexible and fair fashion.