ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

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MEMORANDUM

DATE: September 3, 2010

TO: Members of the Medicaid Advisory Committee

FROM: Julie Hamos
Director

RE: Medicaid Advisory Committee (MAC) Meeting

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The next meeting of the Medicaid Advisory Committee is scheduled for September 17, 2010. With a full complement of members now serving on the MAC, we look forward to a robust discussion of the challenges facing the Department and to having the committee's input on these challenges. The MAC membership can be viewed on-line at: http://www.hfs.illinois.gov/mac/members.html

The meeting will be held via videoconference from 10 a.m. to 12 p.m. Those attending in Springfield will meet at 201 South Grand Avenue East, 3rd floor Video-conference Room B. Those attending in Chicago will meet at 401 South Clinton, 7th floor Video-conference Room. The following meeting material has been posted to the department's Web site: the agenda for the September 17, 2010 meeting and the draft minutes/attachments from the June 18, 2010 meeting. The material has been sent to the committee members electronically. Interested parties can access the meeting information by going to: http://www.hfs.illinois.gov/mac/news/index.html

In order to receive information on future MAC meetings, you will need to register to receive e-mail notification when information is posted to the MAC Web page. To register to receive the MAC e-mail notifications go to: http://www.hfs.illinois.gov/mac/notify.html

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

Medicaid Advisory Committee

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

September 17, 2010
10 a.m. - 12 p.m.

Agenda

I. Call to Order

II. Introductions of New MAC Members

III. Review of June 18, 2010 Meeting Minutes

IV. Director's Report

- Health Care Reform
  - Extension of FMAP
  - Illinois Health Reform Implementation Council
- Other Updates

V. Old Business

- All Kids Update
- PCCM Update
- DM Update

VI. New Business

- Children's Healthcare Quality Initiatives
- Review of By-laws
- 2011 Meeting Dates
- Open to Committee

VII. Subcommittee Reports

- Long Term Care (LTC) Subcommittee – Report
- Public Education Subcommittee – Report
- Pharmacy Subcommittee – No report

VIII. Adjournment

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
June 18, 2010

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

Members Present
Eli Pick, Chairman
Susan Hayes Gordon, Children's Memorial Hospital
John Shlofrock, Barton Mgt.
Jessica Ledesma for Mary Driscoll, DPH
Karen Moredock, DCFS
Kathy Chan for Robyn Gabel, IMCHC

Members Absent
Robert Anselmo, R.Ph.
Pedro A. Poma, M.D.
Kim Mitroka, Christopher Rural Health
Neil Winston, M.D.
Richard Perry, D.D.S.
Myrtis Sullivan, DHS

HFS Staff
Julie Hamos
Theresa Eagleson
Jacquetta Ellinger
Angie Lobo
Amy Harris
Mary Miller
Jamie Tripp
Katey Staley
Sharon Pittman
Stephanie Hoover
Kelly Cunningham
Barb Ginder
James Monk

Interested Parties
Chester Stroyny, APS Healthcare
Mandy Ungrittanon, Quest Diagnostics
Robin Scott, Chicago DPH
Mary Capetillo, Lilly
Mike Lafond, Abbott
Kathy Bovid, Bristol Myers Squibb
Andrea Kovach, Shriver Nat'l. Center on Poverty Law
Judy King
Vince Keenan, IL Academy of Family Physicians
Cher Beilfus, Genentech
Deila Davis, ACHN
Roy Pura, GSK
Glenn Johnston, GSK
Marvin Hazelwood, Consultant
Eva Kraemer, Hemophilia Foundation of Illinois
Jo Ann Spoor, IL Hospital Association
Citseko Staples, Harmony/Wellcare
Jan Costello, Illinois Home Care & Hospice Council
George Hovanec, Children's Memorial
Deb Matthews, DSCC
Lora McCurdy, IARF
Georgia Winson, TAP
Martha Wright, Compreh. Bleeding Disorders Center
Mary Reis, DCFS

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
June 18, 2010

I. Call to Order

Chairman Pick called the meeting to order at 10:06 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Review of the Minutes

The March minutes were approved with a change to add one attendee.

IV. Director's Report

Julie Hamos was introduced as the new HFS director. Director Hamos provided the report.

Health Care Reform: The handout, *Summary of Federal Health Care Changes Related to Medicaid* was provided (Attachment 1). The enhanced federal match has been an important revenue source for states but is due to expire on November 30, 2010. There has been a big push to extend the enhanced rates through June 30, 2011. However, to date, Congress has rejected this request.

FY11 budget: The impact of not extending the enhanced FMAP for Illinois is a revenue reduction of $750 million. The state is struggling with a tough budget that the Governor inherited. There is a big commitment to Medicaid, especially in light of the 63% federal match.

Nursing home reform: The department is excited about nursing home reform. New legislation will create opportunities for important changes in nursing homes. Healthcare and Family Services will convene work groups all summer and present recommendations to legislators to add reforms. Theresa Eagleson, Administrator for the Division of Medical Programs, indicated that the first workgroup meeting is confirmed for July 7th, from 11 a.m. to 1 p.m. at a location in Chicago and Springfield. The workgroup will include long-term care researcher and University of Michigan professor, Dr. Brant Fries. Dr. Fries is the originator of the concept of Resource Utilization Groups (RUG-III), a case-mix system for nursing home residents, used as a tool to pay nursing homes.

Integrated Care RFP Update: The department received five responses that are currently being evaluated. Integrated Care is a new model to deliver services and a major department initiative. This initiative will fit as a model with national health care reform and with the new emphasis on prevention and wellness through primary care.

Citseko Staples asked what efforts have been made to compel passage of the extended FMAP. Director Hamos stated that state government has played an active role, but not

aware of any grassroots efforts as yet. Several participants advised that their organizations have been encouraging legislative support. Chairman Pick stated that there had been significant efforts to request legislative leaders to extend FMAP and be aware of the devastating financial effect of losing the enhanced match including loss of staff.

V. Old Business

1) **All Kids and FamilyCare update.** Theresa Eagleson provided the report. The All Kids Unit (AKU) is making an extra effort to stay current on processing renewals. The AKU has shifted some of the initial eligibility staff to process renewals. A handout, *All Kids Enrollment,* was provided and the statistics were discussed (Attachment 2). More program statistics are being made available on the department web site at: http://www.hfs.illinois.gov/statistics/

   Lora McCurdy asked if there is data on kids who need follow-up on EPSDT (Early and Periodic Screen for Diagnosis and Treatment of Children) services. Jacquetta Ellinger, Deputy Administrator for Policy Coordination, stated that this is difficult to measure. The department has a CHIPRA grant and is working in partnership with the state of Florida and other groups to develop quality measures and making a stronger connection with the medical home concept.

   Director Hamos stated that participants might have heard of the State Inspector General's audit report of the All Kids program. The department is taking a hard look at how we enroll and re-enroll. Once the data is compiled, it will be shared with the MAC and other stakeholders.

   Andrea Kovach stated that she understood that HFS was being audited every year and asked the director if she knew the cost. Director Hamos did not have information on cost, but did say a new audit begins next week.

   Judy King asked about a report completed by OIG and HHS on EPSDT. She believed the report covered nine states including Illinois and is interested in what the findings were. Ms. Ellinger stated that an audit had been completed by the U.S. DHHS Office of Inspector General in 2007. Since then, the department has seen gains in EPSDT participation. The emphasis on medical homes has helped strengthen systems. The department has seen the benefit of PCCM taking hold. She stated that the department could include a reference to the report and have a presentation on the CHIPRA Quality Grant activity.

   Ms. McCurdy remarked that she had read in the HFS handbook about screening for autism. She stated that it would be helpful to have data on this screening.

2) **Primary Care Case Management (PCCM) activity.** Amy Harris, with the Division of Medical Programs, provided the update. She advised that the department has completed

the rollout of the edit that restricts enrollees to going to their own Primary Care Provider (PCP). She reviewed a handout, *Illinois Health Connect Referral Summary*, which showed 8,287 referrals made in the period from October 1, 2009 through May 31, 2010 (Attachment 3).

PCP Referral System: Ms. Harris stated that the PCP may submit a referral for their enrollees via the provider portal, fax or by phone to IHC (Illinois Health Connect). She noted that providers were notified when a PCP referral was needed. She referred to the handout, *Illinois Health Connect Medical Edit Report by Region* (Attachment 4). There were 100,000 edits completed during the period and that HFS had staff to assist in re-billing. There were messages sent to each provider saying if no referral, no payment next time.

Vince Keenan noted that the chart shows exceptions and that the number is much lower than expected. He stated that with good education and rollout, there have been little or no complaints or worries with the process. He added that the chart doesn't show the millions of successful referrals. Ms. Eagleson added that the department receives about 2.5 million claims per month.

Specialty Care: Ms. Harris stated that last February, the department wanted to broaden access to specialty care for participants and increased payment rates for some specific procedure codes. She reviewed a handout, *Specialty Care*, showing increased utilization for specific consultation and initial evaluation for youth and elderly patient preventive service codes (Attachment 5). The department found that the rate increases drove more services to be provided/billed. Mary Miller, from the Division of Medical Programs, stated that there was a connection between the increased payment rate with a reduction in requests for acute and emergency room services, but that it is difficult to establish a correlation or cause/effect relationship. For example, more frequent doctor visits may result in higher emergency service rates. She noted that there are about 25,000 members that use emergency room services regardless of what we do.

Chairman Pick asked if the overall effect is we spend more as a result of consuming more services, what benefits do we see? For example, is there savings as a result of seeing the patient in the doctor's office rather than the emergency room? Ms. Miller stated that the department does see increases in doctor's visits and pharmacy utilization. This is positive. The department also found that inpatient admissions are down 5 percent. This shows cost avoidance and likely better health outcomes. Hospitalization represents the absolute highest costs to the department. Chairman Pick stated that maintaining patient function and preventing function loss is an important dynamic to capture. Susan Gordon Hayes stated that providers are happy to see these increases but added that there is still a whole host of codes for which providers want increased rates. She added that providers are eager to work on improving patient access.

Quality Initiatives: Ms. Harris provided a PowerPoint handout, *Illinois Health Connect Quality Efforts* (Attachment 6). Illinois Health Connect (IHC) outreach efforts to clients and providers were discussed. Ms. Hayes Gordon asked if a question about referral to specialty care could be added to the provider satisfaction survey. It was also noted that the survey completion is anonymous so that it is not possible to follow up when a survey participant is dissatisfied.

There was group discussion on the developmental screening metric. Ms. Kovach stated the increase in the clinical metric examples was good, but it appeared that developmental screenings were a low percentage. Ms. King also found the metric to be a low percentage and asked if there could be more of a geographic breakdown. Group members were interested in learning the national benchmark for developmental screening and strategies to move to improved services. Ms. McCurdy encouraged coordination with Early Intervention programs. It was also suggested to work more closely with the ICAAP (Illinois Chapter of the American Academy of Pediatrics) and link developmental screening with screening for autism.

Bonus Payments: Ms. Harris reviewed several handouts including: *2009 Illinois Health Connect Bonus Payment for High Performance Program Summary* (Attachment 7)*; Illinois Health Connect 2010 Bonus Payment for High Performance* (Attachment 8); and the handout, *2008, 2009 and 2010 Bonus Program Benchmarks by Measurement* (Attachment 9). This last handout showed an increasing percentage of bonuses in each measurement category over time.

Ms. Harris reviewed how the HEDIS 50th percentile is the benchmark and that we have increased the benchmark for receiving the bonus payments each year. Ms. Eagleson clarified that while 88 percent of providers have received a bonus, it may be for only one of the bonus measurements. Director Hamos noted increased interest in rolling out electronic medical records and getting providers up to speed to get additional bonuses through healthcare reform. Our experience with the PCCM bonus system is a good base for training providers.

3) **Your Healthcare Plus (YHP) Disease Management Quality Initiatives:** Ms. Miller reviewed the handout, *Your Healthcare Plus PY3 Clinical Metrics* (Attachment 10). She stated that HFS has a risk-based contract for disease management (DM) with a vendor, McKesson Health Solutions, and 20 percent of the contract is for clinical measures. There are 265,000 persons covered with about half being disabled adults in either the community or long-term care. McKesson provides case management services on a voluntary basis. YHP uses a risk stratification system focusing services to those most at risk. YHP provides information on clinical measures to providers. The measures are based on established standards of professional groups.

In addition to these, YHP also does pharmacy reviews and compares usage to algorithms, results of which are shared with providers. Messages are sent to about

25,000 providers serving 6,000 to 7,000 patients. Part of the messaging shows any contraindication of medications for patients with nine or more prescriptions. This covers several thousand patients.

Mr. Keenan stated that these programs have saved the state about $500,000 each year in 2008 and 2009. He would like to see a fiscal review of Illinois Health Connect to ensure a positive recognition for these programs. Highlighting these programs is good not only to change the Medicaid market but the whole medical market in Illinois.

In response to a question about measuring needed specialty care, Ms. Miller stated that the department looks at pharmacy usage that reflects receiving specialty care. She advised that measuring receipt of needed care is very complex. Persons may have four core chronic health conditions. The department knows that about 25 percent of the DM population has mental health needs. McKesson helps to ensure that patients make the connection to specialty care. The DM program also assists with connections to other service needs like medical transportation and housing. The department looks at case studies as part of the analysis.

Illinois is a paper access system. With Electronic Medical Records (EMR) coming as part of healthcare reform, the department plans to do more with a flat screen system to upload patient specific data electronically. Director Hamos stated that the department's antiquated technology is a challenge. The federal government is incentivizing to update technology. This will help the department.

Ms. Harris noted that providers may use the HFS MEDI system to access data for both Illinois Health Connect and Your Healthcare Plus. Ms. Miller stated that the department is beginning to work with high volume FQHCs (Federally Qualified Health Care Centers) using data in aggregate form to assist with quality assurance and outreach to their sites.

Delia Davis asked if there is any data to show the impact of the FQHCs and their role in carrying out health care reform initiatives. Ms. Miller stated that the department does trending reports and looks at any program doing similar work. This includes other large providers. The department looks at ER utilization, hospital admissions and readmissions and partners with the Illinois Primary Health Care Association.

Mental Illness/Medical Homes: Ms. Miller reviewed the handout, *PCCM Clients with a Mental Health Diagnosis FY09* (Attachment 11). She advised that the chart is for PCCM enrolled patients only. She noted that two-thirds of patients with mental health needs are receiving care from a PCP and about one-third from a psychiatrist.

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
June 18, 2010

VI. New Business

1) **Data on Eye Exams for Children:** Ms. Eagleson reviewed the handout *HFS Billed Eye Exams Between 9-1-08 and 10-15-09 for Children 5 Years Old* (Attachment 12). There is approximately 91,000 children age 5 years old receiving medical coverage. This includes about 45,000 children in Cook County and about 46,000 children downstate. There was billing for eye care services for 31 percent of children in Cook County and 45 percent of children downstate.

   Ms. King noted that we had seen data at the last meeting for Chicago Public Schools (CPS) that showed only 5 percent of children received eye care services. She stated that CPS has not reported data for several years. She added that advocates would need complete data to develop strategies to improve conditions. Ms. Eagleson stated there had been some discussions with CPS and they acknowledge that data is limited and some data has not yet been reported.

   Director Hamos shared that department staff have met with members of the advocacy group, "Prevent Blindness America" and that nationally there is a bigger focus on preschool children getting services.

2) **Open to Committee**

- Director Hamos stated that the department is moving away from the monthly medical card to a more durable medical identification card. She added that teaching providers to use the MEDI system to check eligibility goes along with this.

- Ms. Winson suggested that the department focus on better use of EPSDT data.

- Ms. King asked for the next meeting to review the 416 EPSDT report.

VII. Subcommittee Reports

Long Term Care (LTC): Kelly Cunningham, Chief of the Bureau of Long Term Care, provided the report. The subcommittee met on June 11, 2010 and discussed a number of important LTC related changes. The "Money Follows the Person" program will be extended to 2016. The time frame to move from LTC to the community and become eligible for services has been decreased from 6 months to 90 days. There are also new income eligibility standards for waiver services. The subcommittee discussed the Nursing Home Task Force report and Senate Bill 326. The final report of the Nursing Home Safety Task Force was presented to the Governor in February. Three major areas are emphasized. There is a need for more intense effort to screen residents for level of care and criminal history. The report encourages nursing homes to increase their staffing levels. The report recommends

establishing certifications for mental illness or behavioral risk. HFS is starting a workgroup to recommend changes. The committee will complete their report on November 1, 2010.

The next LTC subcommittee meeting is September 10, 2010.

Public Education Subcommittee: Ms. Ellinger reported that the next workgroup meeting is scheduled for June 25, 2010. The meeting notice has been posted and agenda items include the All Kids survey and change to a permanent medical ID card. She asked that individuals let Carolyn Eddleton or her know if they are not getting the meeting notices.

Pharmacy Subcommittee: No report for this period.

VIII. The meeting was adjourned at 12:19 p.m. The next MAC meeting is scheduled for September 17, 2010.

Enhanced Matching Funds and Maintenance of Effort Requirements

- HR4213, which has passed both houses of Congress and is in a Conference Committee, continues enhanced federal support (FMAP) until June 30, 2011, as assumed in Governor's proposed budget. Maintenance of Effort (MOE) requirements on eligibility processes remain in place and are expanded to CHIP. Payment parameter requirements remain in place as well.

Medicaid Eligibility Changes and Expansion

- Ensures all low-income Americans have access to health insurance, including Medicaid.
- Establishes a national minimum Medicaid standard of 133% FPL for children and adults under age 65, beginning January 1, 2014.
- Illinois' current Medicaid income levels (FPL) by category of eligibility are: Children – 133% (with some infants at 200%); Parents and Caretaker Relatives – 185% (pending approval with federal CMS); Pregnant Women – 200%; Seniors (65+) – 100%; People with permanent disabilities and people who are blind – 100%.
- Beginning in 2014, the state will no longer have to do state disability determinations, as people will not have to prove disability status to be eligible.
- Maintain current income eligibility levels for Medicaid and CHIP until 2019. (Exchange may subsidize some over 133% FPL at state option, once certified).
- All states must use modified adjusted gross income for Medicaid eligibility determinations and the federal subsidy to purchase health insurance coverage. (Must <u>not</u> use to reduce eligibility from current).

Physician Rate Requirement

- Effective January 2013, Medicaid program mandated to pay at least Medicare physician reimbursement rates for primary care services. In 2013 and 2014, 100% federal match for the incremental increase portion over the applicable rates in the state's Medicaid plan in place as of July 1, 2009.
- In 2015, states would either have to maintain the higher reimbursement rates (estimated at $500-600M) without the enhanced federal match or reduce their rates.

Pharmacy Changes

- 2010 – Extend drug rebate to Medicaid managed care plans.
- 2010 – Change in sharing of Medicaid drug rebates with feds which will affect the amount of supplemental rebates the state is currently receiving (estimated loss of $60M - $70M annually).
- 2010 – Federal absorption of some of cost of Part D "Donut Hole" effective January 1, 2011. Illinois' FY2011 Illinois Cares Rx savings estimated at $10M for FY11 and $20M annually.

Disproportionate Share Payment Changes

- HHS Secretary to develop methodology for DSH reductions, imposing the largest reduction in DSH allotments for states with lowest percentage of uninsured or those that do not target DSH payments. Impose smaller reductions for low-DSH states and account for DSH allotments used for 1115 waivers.

Health Insurance Exchanges

- Maintain current Medicaid eligibility levels for adults until Exchange is fully operational (and certified).
- 2014 – Require states to develop a single form for applying for state health subsidy programs and the Exchange that can be filed online, in person, by mail or by phone. Requires coordination with Medicaid / CHIP eligibility functions.
- Federal subsidies also available through the Exchange, beginning in 2014, for qualifying individuals up to 400% FPL.

Quality/Health System Performance

- 2011 – Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- 2011 – Option to create a new Medicaid "health home" for enrollees with chronic conditions, including serious mental illness.
- 2012 – Option to create pediatric Accountable Care Organizations.

Prevention/Wellness

- 2010 – Require Medicaid coverage for tobacco cessation services for pregnant women (already doing).
- 2011 – Eliminate cost sharing for preventive services in Medicare and Medicaid (already doing / assumed in budget).
- 2011 – Increase FMAP by 1 percentage point for states providing Medicaid coverage for preventive services and immunizations recommended by US Preventive Services Task Force.

Long-Term Care

- Oct. 2010 – Changes state plan option (1915i) to increase the income standard (from 150% to 300% SSI) under which state can provide home and community-based services (HCBS) and requires such services to be statewide.
- Oct. 2011 – State plan option (1915k) to establish a state plan amendment to provide community-based attendant supports and services to individuals with disabilities needing institutional levels of care, including IMDs (Community First Option). Provides for 6 percentage point additional federal match, which sunsets after five years.
- MFP Demonstration extended to 2016 and minimum stay for transition eligibles reduced from six months to three months.

All Kids Enrollment

MAC 6/18/10

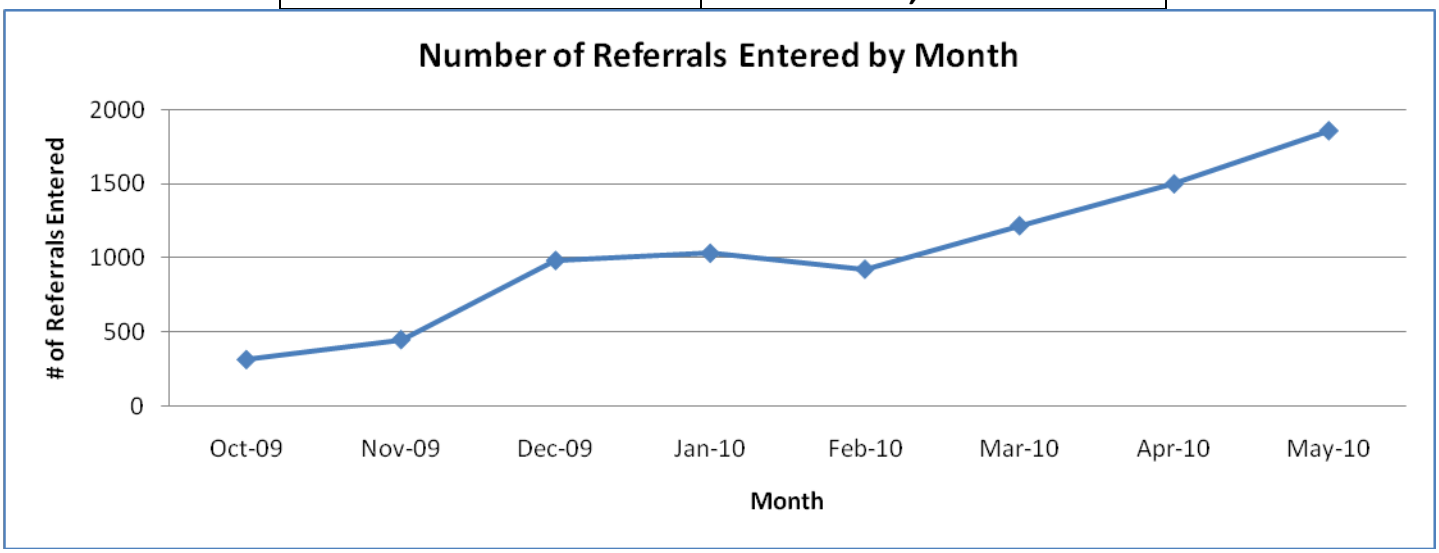
Program	Dec-09		Jan-10		Feb-10	Mar-10	Apr-10
	Previous	Current	Previous	Current	Current	Current	Current
All Kids Assist	1,517,708	1,521,753	1,520,247	1,528,218	1,532,753	1,537,007	1,538,548
All Kids Share All Kids Premium 1 All Kids Rebate	74,704	74,687	74,801	74,568	74,408	74,265	74,274
All Kids Premium 2-8	19,127	19,119	19,406	19,316	19,409	19,440	19,825
All Kids Total	**1,611,539**	**1,615,559**	**1,614,454**	**1,622,102**	**1,626,570**	**1,630,712**	**1,632,647**

Illinois Health Connect Referral Summary

Attachment 3
MAC Meeting Minutes – June 18, 2010

Referrals Entered by Month (10/1/09-5/31/10):

Month	# of Referrals Entered
October 2009	314
November 2009	449
December 2009	984
January 2010	1,033
February 2010	925
March 2010	1,219
April 2010	1,502
May 2010	1,861
Total	**8,287**



Referral Entry Points (10/1/09-5/31/10):

Entry Point	# of Referrals Entered
IHC Provider Portal (Web)	4,182
Fax	2,984
Phone	1,121
Total	**8,287**

Provider Education:

During the months of September 2009-March 2010, IHC assisted practices prepare for and implement Phase 1 of the Illinois Health Connect Referral System by offering 29 webinars and 13 face-to-face trainings in all Regions of the State.

For Discussion Purposes Only

Illinois Health Connect Medical Home Edit Report by Region

G11 Edits by Region

		NW	Collar	Cook	Central	Southern
Oct-09	G11	538				
Nov-09	G11	5,873				
Dec-09	G11	4,481	4,134			
Jan-10	G11	3,707	5,541			
Feb-10	G11	2,194	3,277	2,372		
Mar-10	G11	3,333	5,224	15,056		
Apr-10	G11	2,400	4,220	13,450	2,735	2,453
May-10	G11	1,647	3,439	10,387	2,495	1,956
		24,173	25,835	41,265	5,230	4,409
				100,912		

I14 Informational Edits by Region

		NW	Collar	Cook	Central	Southern
Oct-09	I14	3,330	17,542	36,509	10,574	11,871
Nov-09	I14	1,499	17,504	38,522	11,159	13,662
Dec-09	I14	633	7,722	37,495	11,453	12,821
Jan-10	I14	397	3,895	30,429	10,592	10,048
Feb-10	I14	793	2,420	13,368	9,702	10,747
Mar-10	I14	7,982	11,281	52,525	20,692	21,941
Apr-10	I14	2,283	4,045	19,039	6,452	6,130
May-10	I14	123	341	4,818	921	525
		17,040	64,750	232,705	81,545	87,745
			483,785			

*The Department receives almost 2.5 million claims from physicians and FQHCs a month. On average, approximately 1% of these claims results in a G11 edit due to a lack of a referral.

Attachment 5
MAC Meeting Minutes
June 18, 2010

Specialty Care

QTR	YYYY_MM	ProcCd	PCCM enrollees - procs	non-PCCM enrollees - procs	Total Procs (all enrollees)	Total Providers billing	PCPs billing	procs per 1,000 enrollees (all clients)	procs per 1,000 enrollees (PCCM only)
99241 -Consult New/Est Pt Office 0 - 20 yr									
08	2008-10	99241	518	322	840	302	35	0.337	0.316
08	2008-11	99241	446	250	696	267	27	0.279	0.272
08	2008-12	99241	440	237	677	276	33	0.271	0.268
08 TOTAL		**99241**	**1,404**	**809**	**2,213**	**627**	**88**	**0.887**	**0.856**
09	2009-04	99241	554	340	894	340	38	0.328	0.305
09	2009-05	99241	472	269	741	307	31	0.272	0.259
09	2009-06	99241	521	304	825	342	41	0.302	0.286
09 TOTAL		**99241**	**1,547**	**913**	**2,460**	**564**	**76**	**0.902**	**0.850**
09	2009-10	99241	536	287	823	314	39	0.310	0.306
09	2009-11	99241	485	206	691	262	27	0.261	0.277
09	2009-12	99241	415	174	589	253	32	0.222	0.237
09 TOTAL		**99241**	**1,436**	**667**	**2,103**	**654**	**82**	**0.793**	**0.819**
99242 - Consult New/Est Pt Office 0 - 20 yr									
08	2008-10	99242	1,812	1,072	2,884	1,064	136	1.155	1.105
08	2008-11	99242	1,377	848	2,225	924	103	0.891	0.840
08	2008-12	99242	1,339	831	2,170	852	101	0.869	0.817
08 TOTAL		**99242**	**4,528**	**2,751**	**7,279**	**1,885**	**290**	**2.916**	**2.762**
09	2009-04	99242	1,933	1,106	3,039	1,113	145	1.114	1.063
09	2009-05	99242	1,656	1,023	2,679	1,039	138	0.982	0.910
09	2009-06	99242	1,859	1,074	2,933	1,080	155	1.075	1.022
09 TOTAL		**99242**	**5,448**	**3,203**	**8,651**	**1,828**	**264**	**3.172**	**2.995**
09	2009-10	99242	1,892	1,018	2,910	1,054	113	1.097	1.080
09	2009-11	99242	1,575	823	2,398	967	131	0.904	0.899
09	2009-12	99242	1,567	702	2,269	896	109	0.856	0.894
09 TOTAL		**99242**	**5,034**	**2,543**	**7,577**	**2,019**	**312**	**2.857**	**2.873**

QTR	YYYY_MM	ProcCd	PCCM enrollees - procs	non-PCCM enrollees - procs	Total Procs (all enrollees)	Total Providers billing	PCPs billing	procs per 1,000 enrollees (all clients)	procs per 1,000 enrollees (PCCM only)
99243 - Consult New/Est Pt Office 0 - 20 yr									
08	2008-10	99243	4,958	3,234	8,192	2,645	281	3.282	3.024
08	2008-11	99243	3,846	2,619	6,465	2,328	239	2.590	2.346
08	2008-12	99243	4,010	2,594	6,604	2,381	278	2.646	2.446
08 TOTAL		**99243**	**12,814**	**8,447**	**21,261**	**4,105**	**533**	**8.517**	**7.815**
09	2009-04	99243	5,711	3,389	9,100	2,747	303	3.336	3.140
09	2009-05	99243	4,986	3,163	8,149	2,622	292	2.988	2.741
09	2009-06	99243	5,013	3,324	8,337	2,585	278	3.056	2.756
09 TOTAL		**99243**	**15,710**	**9,876**	**25,586**	**4,183**	**525**	**9.380**	**8.636**
09	2009-10	99243	5,389	3,230	8,619	2,673	290	3.250	3.075
09	2009-11	99243	4,660	2,628	7,288	2,468	243	2.748	2.659
09	2009-12	99243	4,487	2,361	6,848	2,335	248	2.582	2.561
09 TOTAL		**99243**	**14,536**	**8,219**	**22,755**	**4,364**	**564**	**8.581**	**8.295**
99244 - Consult New/Est Pt Office 0 - 20 yr									
08	2008-10	99244	4,995	4,204	9,199	2,968	231	3.685	3.046
08	2008-11	99244	3,988	3,155	7,143	2,597	190	2.862	2.432
08	2008-12	99244	3,898	3,082	6,980	2,586	195	2.796	2.377
08 TOTAL		**99244**	**12,881**	**10,441**	**23,322**	**4,288**	**398**	**9.343**	**7.856**
09	2009-04	99244	5,603	4,271	9,874	3,009	220	3.620	3.080
09	2009-05	99244	5,151	3,915	9,066	2,880	216	3.324	2.832
09	2009-06	99244	5,450	4,229	9,679	2,957	215	3.548	2.996
09 TOTAL		**99244**	**16,204**	**12,415**	**28,619**	**4,609**	**414**	**10.492**	**8.908**
09	2009-10	99244	5,846	4,186	10,032	3,030	242	3.783	3.336
09	2009-11	99244	5,078	3,294	8,372	2,757	212	3.157	2.898
09	2009-12	99244	4,923	2,951	7,874	2,618	163	2.969	2.809
09 TOTAL		**99244**	**15,847**	**10,431**	**26,278**	**4,739**	**433**	**9.910**	**9.044**

QTR	YYYY_MM	ProcCd	PCCM enrollees - procs	non-PCCM enrollees - procs	Total Procs (all enrollees)	Total Providers billing	PCPs billing	procs per 1,000 enrollees (all clients)	procs per 1,000 enrollees (PCCM only)
99245 - Consult New/Est Pt Office 0 - 20 yr									
08	2008-10	99245	1,593	1,782	3,375	1,385	65	1.352	0.972
08	2008-11	99245	1,353	1,506	2,859	1,240	75	1.145	0.825
08	2008-12	99245	1,343	1,350	2,693	1,216	62	1.079	0.819
08 TOTAL		**99245**	**4,289**	**4,638**	**8,927**	**2,163**	**125**	**3.576**	**2.616**
09	2009-04	99245	1,791	1,717	3,508	1,419	79	1.286	0.985
09	2009-05	99245	1,507	1,596	3,103	1,315	76	1.138	0.828
09	2009-06	99245	1,547	1,646	3,193	1,334	76	1.171	0.850
09 TOTAL		**99245**	**4,845**	**4,959**	**9,804**	**2,316**	**118**	**3.594**	**2.664**
09	2009-10	99245	1,639	1,605	3,244	1,373	66	1.223	0.935
09	2009-11	99245	1,468	1,473	2,941	1,263	64	1.109	0.838
09	2009-12	99245	1,424	1,267	2,691	1,196	55	1.015	0.813
09 TOTAL		**99245**	**4,531**	**4,345**	**8,876**	**2,403**	**145**	**3.347**	**2.586**
99385 - Initial Eval Healthy 18 - 39 Yrs; Prventive									
08	2008-10	99385	753	240	993	484	313	0.398	0.459
08	2008-11	99385	624	194	818	420	270	0.328	0.381
08	2008-12	99385	569	172	741	414	250	0.297	0.347
08 TOTAL		**99385**	**1,946**	**606**	**2,552**	**828**	**559**	**1.022**	**1.187**
09	2009-04	99385	938	272	1,210	578	374	0.444	0.516
09	2009-05	99385	804	273	1,077	521	360	0.395	0.442
09	2009-06	99385	930	273	1,203	573	384	0.441	0.511
09 TOTAL		**99385**	**2,672**	**818**	**3,490**	**1,190**	**796**	**1.279**	**1.469**
09	2009-10	99385	1,251	360	1,611	674	452	0.608	0.714
09	2009-11	99385	1,037	342	1,379	632	407	0.520	0.592
09	2009-12	99385	1,048	322	1,370	587	376	0.517	0.598
09 TOTAL		**99385**	**3,336**	**1,024**	**4,360**	**1,076**	**718**	**1.644**	**1.904**

QTR	YYYY_MM	ProcCd	PCCM enrollees - procs	non-PCCM enrollees - procs	Total Procs (all enrollees)	Total Providers billing	PCPs billing	procs per 1,000 enrollees (all clients)	procs per 1,000 enrollees (PCCM only)
99386 - Initial Eval Healthy 40 - 64 Yrs; Prventive									
08	2008-10	99386	231	80	311	206	116	0.125	0.141
08	2008-11	99386	168	44	212	152	83	0.085	0.102
08	2008-12	99386	163	53	216	160	99	0.087	0.099
08 TOTAL		**99386**	**562**	**177**	**739**	**345**	**192**	**0.296**	**0.343**
09	2009-04	99386	298	85	383	241	150	0.140	0.164
09	2009-05	99386	301	68	369	243	148	0.135	0.165
09	2009-06	99386	303	86	389	259	168	0.143	0.167
09 TOTAL		**99386**	**902**	**239**	**1,141**	**562**	**381**	**0.418**	**0.496**
09	2009-10	99386	364	83	447	288	203	0.169	0.208
09	2009-11	99386	380	82	462	268	181	0.174	0.217
09	2009-12	99386	284	72	356	237	155	0.134	0.162
09 TOTAL		**99386**	**1,028**	**237**	**1,265**	**529**	**332**	**0.477**	**0.587**
99387 - Initial Eval Healthy 65 Yrs and Greater; Preventive									
08	2008-10	99387	4	6	10	10	6	0.004	0.002
08	2008-11	99387	7	6	13	11	6	0.005	0.004
08	2008-12	99387	6	2	8	6	4	0.003	0.004
08 TOTAL		**99387**	**17**	**14**	**31**	**35**	**19**	**0.012**	**0.010**
09	2009-04	99387	7	11	18	16	12	0.007	0.004
09	2009-05	99387	18	9	27	18	14	0.010	0.010
09	2009-06	99387	16	11	27	22	18	0.010	0.009
09 TOTAL		**99387**	**41**	**31**	**72**	**53**	**43**	**0.026**	**0.023**
09	2009-10	99387	18	10	28	24	21	0.011	0.010
09	2009-11	99387	19	6	25	22	16	0.009	0.011
09	2009-12	99387	12	6	18	16	14	0.007	0.007
09 TOTAL		**99387**	**49**	**22**	**71**	**53**	**41**	**0.027**	**0.028**

QTR	YYYY_MM	ProcCd	PCCM enrollees - procs	non-PCCM enrollees - procs	Total Procs (all enrollees)	Total Providers billing	PCPs billing	procs per 1,000 enrollees (all clients)	procs per 1,000 enrollees (PCCM only)
99395 - Periodic Reeval/Mgmt 18 - 39 Yrs; Preventive									
08	2008-10	99395	3,960	836	4,796	1,475	950	1.921	2.415
08	2008-11	99395	3,000	688	3,688	1,315	851	1.477	1.830
08	2008-12	99395	2,775	622	3,397	1,235	779	1.361	1.692
08 TOTAL		**99395**	**9,735**	**2,146**	**11,881**	**2,216**	**1,534**	**4.760**	**5.937**
09	2009-04	99395	4,658	1,042	5,700	1,613	1,043	2.090	2.561
09	2009-05	99395	3,957	935	4,892	1,572	1,009	1.793	2.175
09	2009-06	99395	4,619	1,100	5,719	1,727	1,165	2.097	2.539
09 TOTAL		**99395**	**13,234**	**3,077**	**16,311**	**2,678**	**1,827**	**5.980**	**7.275**
09	2009-10	99395	5,117	1,063	6,180	1,770	1,158	2.331	2.920
09	2009-11	99395	4,471	942	5,413	1,613	1,057	2.041	2.551
09	2009-12	99395	4,060	808	4,868	1,527	998	1.836	2.317
09 TOTAL		**99395**	**13,648**	**2,813**	**16,461**	**2,657**	**1,823**	**6.208**	**7.789**
99396 - Periodic Reeval Mgmt 40 - 64 Yrs; Preventive									
08	2008-10	99396	962	265	1,227	693	452	0.492	0.587
08	2008-11	99396	771	217	988	590	377	0.396	0.470
08	2008-12	99396	689	200	889	587	376	0.356	0.420
08 TOTAL		**99396**	**2,422**	**682**	**3,104**	**1,210**	**805**	**1.243**	**1.477**
09	2009-04	99396	1,338	342	1,680	860	553	0.616	0.736
09	2009-05	99396	1,160	315	1,475	838	534	0.541	0.638
09	2009-06	99396	1,292	320	1,612	873	578	0.591	0.710
09 TOTAL		**99396**	**3,790**	**977**	**4,767**	**1,603**	**1,071**	**1.748**	**2.084**
09	2009-10	99396	1,379	294	1,673	935	618	0.631	0.787
09	2009-11	99396	1,244	297	1,541	833	543	0.581	0.710
09	2009-12	99396	1,076	227	1,303	747	501	0.491	0.614
09 TOTAL		**99396**	**3,699**	**818**	**4,517**	**1,624**	**1,058**	**1.703**	**2.111**

QTR	YYYY_MM	ProcCd	PCCM enrollees - procs	non-PCCM enrollees - procs	Total Procs (all enrollees)	Total Providers billing	PCPs billing	procs per 1,000 enrollees (all clients)	procs per 1,000 enrollees (PCCM only)
99397 - Periodic Reeval Mgmt 65 Yrs and Greater; Preventive									
08	2008-10	99397	17	25	42	33	26	0.017	0.010
08	2008-11	99397	25	27	52	49	43	0.021	0.015
08	2008-12	99397	15	13	28	28	23	0.011	0.009
08 TOTAL		**99397**	**57**	**65**	**122**	**87**	**62**	**0.049**	**0.035**
09	2009-04	99397	26	35	61	46	40	0.022	0.014
09	2009-05	99397	31	36	67	57	44	0.025	0.017
09	2009-06	99397	24	28	52	47	37	0.019	0.013
09 TOTAL		**99397**	**81**	**99**	**180**	**108**	**84**	**0.066**	**0.045**
09	2009-10	99397	26	33	59	49	38	0.022	0.015
09	2009-11	99397	27	21	48	38	31	0.018	0.015
09	2009-12	99397	26	17	43	37	30	0.016	0.015
09 TOTAL		**99397**	**79**	**71**	**150**	**135**	**109**	**0.057**	**0.045**

Illinois Health Connect Quality Efforts

June 18, 2010

IHC: Medical Home Edits

- Geographic implementation of Phase I of "Referral System" from Oct 2009 through April 2010.
- Implemented to continue the ongoing efforts to "connect" patients with their PCPs at their medical homes.
- Pts must be seen by their own PCP. PCPs can authorize care by other PCPs through a "referral".
- No referral is required at this time for specialists or other non-PCPs to render care.

Outreach to Clients

- Annual letters to all clients encouraging annual primary/preventive visits/check-ups
- Phone outreach and appt scheduling assistance for pediatric pts for well-child visits
- Semi-annual client newsletter
- Assistance with access to specialty care and community health services such as Early Intervention
- Call center handles 80,000 calls per month

Outreach to Providers

"High Touch"

- Field representatives and QA nurses make approximately 250 visits to provider offices per week to assist with billing/coding, IHC administration, EPSDT standards and clinical quality improvement.
- Advisory subcommittees creates opportunity for stakeholder input
- Information provided via quarterly newsletter, blast fax, IHC website

Outreach to Providers

"High Tech"

- Multiple QA Tools providing large amounts of data to practices
  - Panel Rosters: "wellness" registry
  - Claims History: all encounters for all HFS pts
  - Provider Profiles: feedback on clinical performance
  - MEDI Training and Webinar Sessions
- IHC Annual Bonus Program

Evaluation Strategy Examples

- Enrollee Satisfaction Survey
- PCP Satisfaction Survey
- Clinical metrics

Enrollee Satisfaction Survey: Methodology

- Telephone survey administered to clients enrolled with a PCP for their medical home in IHC for a minimum of six (6) months.
- The data was stratified by clients who live in a rural setting versus clients who live in urban/metropolitan settings using US Census definitions
- Approx 390 respondents from each rural and metro area each yr.

Enrollee Satisfaction Survey: Results

	2009	2010
Metro respondents who were extremely satisfied or satisfied with PCP	**97.4%**	**98.4%**
Metro respondents who were extremely satisfied or satisfied with IHC Program	**94.5%**	**98.8%**
Rural respondents who were extremely satisfied or satisfied with PCP	**97.9%**	**98.2%**
Rural respondents who were extremely satisfied or satisfied with IHC Program	**94.5%**	**96.8%**

Provider Satisfaction Survey: Methodology

- Mailed to all PCPs/medical homes
- Follow-up blast faxes, emails, distribution by field staff and professional societies
- Questions compiled from previous PCP surveys, input from Steering Committee and changes from 2008 survey
- 875 surveys returned in 2009

Provider Satisfaction Survey: Results

Question	2008 Data N= 687		2009 Data N=875	
	SA or A	D or SD	SA or A	D or SD
IHC is beneficial to my patients.	81.3%	12.7%	90.9%	9.1%
Overall, I am satisfied with the administration of IHC.	76.1%	23.9%	84.2%	15.8%
I would recommend IHC to my colleagues.	75.2%	24.8%	77.9%	22.1%

Clinical Metrics Examples

Measure	2007 All IHC pts*	2008 All IHC pts*	2009 All IHC pts*
Children ages 0-3 with at least 1 objective developmental screen	25.5%	29.3%	36.0%**
Women ages 42-69 receiving at least 1 mammogram in measurement yr or yr prior	37.45%	37.32%	38.82%**

* Includes all clients enrolled at the end of the measurement period, does not require continuous enrollment.

** Data compiled 4/7/10. Providers have one year to file claims.

Future Quality Efforts

- Aligning and streamlining quality data provided to PCPs
- Enhancing connections between PCPs and other providers, community resources, etc.
- Moving medical homes to higher standards
- Improving client education through the medical home
- Assessing outcomes through clinical metrics

2009 Illinois Health Connect Bonus Payment for High Performance Program Summary

(Includes 2008 Bonus Program Results)

Program Summary

Of the 4,897 unique providers/sites that could qualify for a bonus under the 2009 bonus payment program, 4,240 qualified (received a bonus) for one or more bonus measurement at one or more site. This means 88% of all eligible PCPs will receive a bonus for 2009. In total, 4,558 sites will receive a bonus. The bonus payment for each qualifying event under the 2009 Bonus Program is $25.00. A total of $3,214,250 will be paid to qualifying PCPs/Sites under the 2009 Bonus Program.

All bonus payments for 2009 will be issued by mail to the PCPs payee the first to second week of July, 2010. PCPs will be able to access the patient specific detail of their bonus payments via the Illinois Health Connect Provider Portal through HFS'secure MEDI system.

Under the 2008 bonus program, bonus payments were issued to 4,123 qualifying providers at 4,430 sites. The bonus payment for each qualifying event under the 2008 Bonus Program was $25.00 and a total of $2,896,125 was paid to qualifying PCPs/Sites.

Quality Measurement Summary

For the 2009 program, HFS looked at 389,610 unique clients under all 5 bonus measurements. For these clients there were 233,968 eligible events. Of these eligible events, 128,570 qualified for a bonus.

Under the 2008 program, HFS looked at 362,050 unique clients under all 5 bonus measurements. For these clients there were 197,071 eligible events. Of these eligible events, 115,845 qualified for a bonus.

2009 Bonus Program		
Measurement	**Qualifying Recipients**	**Bonus Value**
Asthma Mgmt	19,118	$477,950
Breast Cancer	13,055	$326,375
Developmental Screening	66,115	$1,652,875
Diabetes Mgmt	14,077	$351,925
Immunizations	16,205	$405,125
Totals	**128,570**	**$3,214,250**

2008 Bonus Program		
Measurement	**Qualifying Recipients**	**Bonus Value**
Asthma Mgmt	18,730	$468,250
Breast Cancer	11,667	$291,675
Developmental Screening	55,272	$1,381,800
Diabetes Mgmt	10,128	$253,200
Immunizations	20,048	$501,200
Totals	**115,845**	**$2,896,125**

Illinois Health Connect
2010 Bonus Payment for High Performance

The Illinois Department of Healthcare and Family Services is entering into year three of the Illinois Health Connect Bonus Payment program. Under the 2010 program, qualifying Illinois Health Connect Primary Care Providers (PCPs) are eligible to receive annual bonus payments for each qualifying service under a bonus measurement.

What are the Bonus Measurements?

- **Immunization Combo 3:** Children who receive designated immunizations by age 24 months (benchmark 71.8%).
- **Developmental Screening:** Children who receive at least one objective screening by the age of 12 months (benchmark 65%), between the ages of 12 and 24 months (benchmark 55%), and between the ages of 24 and 36 months (benchmark 50%). A bonus will be available for each separate age group.
- **Asthma management:** Patients with persistent asthma, ages 5-9 years (benchmark 92.7%), ages 10-17 years (benchmark 89.6%) and ages 18-56 years (benchmark 85.6%) who fill an asthma controller medication prescription. A bonus will be available for each separate age group.
- **Diabetes Management:** Patients with diabetes, ages 18 to 65 years who receive at least one HbA1c test annually (benchmark 80.7%).
- **Breast Cancer Screening:** Women between ages 40 and 69 who have had a mammogram in the last two years (benchmark 50.5%).

Who is a qualifying PCP?

A qualifying PCP is an Illinois Health Connect PCP who meets or exceeds the benchmarks collectively for all the Illinois Health Connect enrollees on their panel roster for a particular measure. A PCP may be a qualifying PCP for one or more measurement.

How HFS will measure whether you met the benchmark?

HFS will count the number of qualifying patients for each measure enrolled on each PCP's Illinois Health Connect panel roster on December 1, 2010. HFS will then look to see which of those patients received the measured service during the measurement period. HFS claims data will be used to determine whether a service was rendered (for immunizations, Cornerstone and ICARE data will also be used). Although providers have 12 months from the date of service to bill in order to be paid for the service, the bonus payment will be

based on measurement year 2010 claims, after a three month run out (January through March of 2011). This means all claims for measurement year 2010 services must be submitted to HFS prior to April 1, 2011 to be counted. Bonus payments will be determined and paid by June 2011.

PCPs do not have to report any special information to earn a bonus payment; but they need to submit a detailed claim for the services that are rendered. A measured service is counted whether or not it was the current PCP or another provider who rendered the service during the measurement period. HFS will use the date of service for the measured service to determine if it was rendered in the measurement period. Ordering a service for a patient does not qualify for a bonus payment, the service must actually be received by the patient. Additional information about the billing codes for each measure is posted on the Illinois Health Connect website at www.illinoishealthconnect.com under the Quality Tools section.

For which services will bonus payments be made?

If a PCP meets or exceeds the benchmark for a particular measured service, a bonus payment will be made for each patient that received the measured service. If the PCP does not meet the benchmark, there will be no bonus payment made for any patients, whether they received the service or not.

How much are the bonus payments?

The 2010 bonus payments will be at least $20.00 per patient. The bonus payment may be higher depending on the number of qualifying PCPs and the number of patients receiving a measured service from those PCPs as determined by the Department.

EXAMPLE:

For example, for the diabetes measurement, the HEDIS 2009 50th percentile is 80.7%(meaning that half of the nation's Medicaid programs had achieved a rate of 80.7%or higher for diabetic patients receiving at least one HcA1c test). A PCP would need 80.7% or more of their Illinois Health Connect diabetic patients to have received at least one HbA1c test in the past 12 months to qualify for the bonus payment. The PCP would receive the bonus payment for each patient that met the criteria. If less than 80.7% of the Illinois Health Connect diabetic patients on the PCP's panel roster did not have the test, then no bonus would be available for any of their diabetic patients.

2008, 2009 and 2010 Bonus Program Benchmarks by Measurement

Bonus Measurement	Age	2008 Bonus Program	2009 Bonus Program	2010 Bonus Program
Asthma Mgmt	5 – 9 yrs	91.7%	91.8%	92.7%
	10 -17 yrs	88.8%	89.5%	89.6%
	18 – 56 yrs	85.4%	85.8%	85.6%
Breast Cancer Screening	40 to 69 yrs	49.2%	50.1%	50.5%
Diabetes Mgmt	18 to 56 yrs	79.3%	79.6%	80.7%
Immunization Combo 3	By age 24 months	62.6%	68.6%	71.8%
Developmental Screening	By age 12 months	35%	50%	65%
	Between 12 and 24 months	30%	40%	55%
	Between 24 and 26 months	25%	30%	50%

*The HEDIS 50th percentile is the benchmark for the Bonus Payment measurements, except for the Developmental Screenings benchmark, which is established by HFS.

Your Healthcare Plus
PY3 Clinical Metrics

Diabetes	HbA1C testing:	70.96%
	Retinal Exams:	34.21%
	Annual microalbuminaria testing:	59.73%
	Cholesterol testing rate:	69.41%
	Influenza vaccine:	16.08%
	ASA, antiplatelet or anticoagulant:	40.81%
	Statin therapy:	57.50%
	ACE inhibitors/ARBs:	62.53%
CAD	ACE inhibitors/ARBs:	64.17%
	Beta-blocker usage w/in 30 days of MI(when not contraindicated):	38.50%
	Cholesterol testing rate:	69.64%
	Statin therapy:	65.72%
	Pneumococcal vaccine:	10.14%
	Influenza vaccine:	14.63%
	ASA, antiplatelet or anticoagulant:	62.38%
Heart Failure	ACE inhibitor, ARB or hydralazine+isosorbide:	72.55%
	Beta blocker:	64.41%
	Diuretics:	70.13%
	Pneumococcal vaccine:	9.64%
	Influenza vaccine:	13.29%
	ASA, antiplatelet or anticoagulant:	57.40%
Asthma (ABD)	Members with uncontrolled asthma w/ inhaled corticosterid within 30 days of event:	56.00%
	Members with at least one Asthma Controller Medication	63.47%
	Influenza vaccine:	13.35%
COPD	Acute COPD exacerbation w/ corticosteroid:	68.15%
	History of hospitalizations for COPD w/ brochiodilator medications:	87.88%
	Spirometry testing:	30.91%
	Pneumococcal vaccine:	10.78%
	Influenza vaccine:	14.57%
Asthma (Family Health)	Members with uncontrolled asthma w/ inhaled corticosterid within 30 days of event:	40.77%
	Members with at least one Asthma Controller Medication	49.19%
	Influenza vaccine:	18.46%

	FY06	FY07	FY08	FY09
Total Hospitalizations	14,375	10,853	8,767	7,875
Hospitalizations per 1,000	723	622	517	471
Readmissions w/in 30 days	4,483	3,611	3,045	2,754
Readmissions per 1,000	226	207	179	165
Readmission Rate	31.19%	33.27%	34.73%	34.97%
Member Months	238,527	209,453	203,596	200,765
FTE's	19,877	17,454	16,966	16,730
Total MH Hospitalization Costs	$64,605,226	$50,239,411	$39,891,608	$30,650,246
Avg. Cost per Admit	$4,494.28	$4,629.08	$4,550.20	$3,892.09
Estimated (Savings)/Cost from reduced Readmissions		**($1,507,035)**	**($3,555,928)**	**($3,967,138)**

	FY06 (baseline)	FY07 (PY1)	FY08 (PY2)	FY09 (PY3)
ER Visits	16,253	11,949	9,762	8,713
Total MH ER Cost	$2,490,022	1,989,578.59	$1,657,446	$1,526,721
Avg. Cost per ER Visit	$153.20	$166.51	$169.79	$175.22
ER Visits per 1,000	818	685	575	521
Estimated (Savings)/Cost from reduced ER Visits		**($386,775)**	**($697,960)**	**($870,322)**

14-day readmissions

	FY06	FY07	FY08	FY09
Total Hospitalizations	14,375	10,853	8,767	7,875
Hospitalizations per 1,000	723	622	517	471
Readmissions w/in 14 days	2,998	2,417	2,013	1,835
Readmissions per 1,000	151	138	119	110
Readmission Rate	20.86%	22.27%	22.96%	23.30%
Member Months	238,527	209,453	203,596	200,765
FTE's	19,877	17,454	16,966	16,730
Total MH Hospitalization Costs	$64,605,226	$50,239,411	$39,891,608	$30,650,246
Avg. Cost per Admit	$4,494.28	$4,629.08	$4,550.20	$3,892.09
Estimated (Savings)/Cost from reduced Readmissions		**($997,881)**	**($2,484,222)**	**($2,679,226)**

Healthcare and Family Services
Bureau of Rate Devel. and Analysis
Hospital Readmissions and Emergency Department Visits for
Mental Health Diagnoses
All Disease Management Program Enrollees

	FY06 (baseline)	FY07 (PY1)	FY08 (PY2)	FY09 (PY3)
Total Hospitalizations	20,313	18,159	16,994	17,748
Hospitalizations per 1,000	187	171	161	163
Readmissions w/in 30 days	5,553	4,985	4,719	5,009
Readmissions per 1,000	51	47	45	46
Readmission Rate	27.34%	27.45%	27.77%	28.22%
Member Months	1,305,828	1,271,034	1,263,910	1,304,803
FTE's	108,819	105,920	105,326	108,734
Total MH Hospitalization Costs	$90,289,007	$82,427,917	$77,312,086	$68,962,990
Avg. Cost per Admit	$4,444.89	$4,539.23	$4,549.38	$3,885.68
Estimated (Savings) Cost from reduced Readmissions		**($1,906,665)**	**($2,983,235)**	**($2,096,878)**

	FY06 (baseline)	FY07 (PY1)	FY08 (PY2)	FY09 (PY3)
ER Visits	22,024	19,615	19,039	20,058
Total MH ER Cost	$3,374,696	$3,225,344	$3,165,545	$3,458,952
Avg. Cost per ER Visit	$153.23	$164.43	$166.27	$172.45
ER Visits per 1,000	202	185	181	184
Estimated (Savings) Cost from reduced ER Visits		**($299,625)**	**($378,758)**	**($336,052)**

14-day readmissions

	FY06 (baseline)	FY07 (PY1)	FY08 (PY2)	FY09 (PY3)
Total Hospitalizations	20,313	18,159	16,994	17,748
Hospitalizations per 1,000	187	171	161	163
Readmissions w/in 14 days	3,627	3,252	3,039	3,275
Readmissions per 1,000	33	31	29	30
Readmission Rate	17.86%	17.91%	17.88%	18.45%
Member Months	1,305,828	1,271,034	1,263,910	1,304,803
FTE's	108,819	105,920	105,326	108,734
Total MH Hospitalization Costs	$90,289,007	$82,427,917	$77,312,086	$68,962,990
Avg. Cost per Admit	$4,444.89	$4,539.23	$4,549.38	$3,885.68
Estimated (Savings) Cost from reduced Readmissions		**($1,263,537)**	**($2,145,356)**	**($1,356,700)**

Healthcare and Family Services
Billed Eye Exams Between 9-1-2008 and 10-15-2009
for Children 5 Years Old (Public Act 95-671)

	Cook		Downstate	
	# of Children	**Percentage**	**# of Children**	**Percentage**
5 years old on 9-1-2009	45,047		46,490	
Had at least one of vision HCPCS codes between 9-1-2008 and 10-15-2009	12,647	28.1%	18,792	40.4%
With date of service thru 12-12-2009	13,964	31.0%	20,924	45.0%

Codes
92002 - New Eye Exam-Trtmt. Interim.
92004 - New Eye Exam-Trtmt. Compreh.
92012 - Eye Exam-Trtmt.
92014 - Eye Exam-Trtmt.
92015 - Determination of refractive state

Notes:
Providers have 1 year from date of service to submit claim to HFS.
ISBE - Student Health Data Vision System's on-line survey deadline June 30th.