Medicaid Advisory Committee
Care Coordination Subcommittee

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

January 6, 2015
10:00 a.m. – 12:00 p.m.

Conference Call-In Number: 888-494-4032
Access Code: 1731617433

Agenda

I. Call to Order

II. Introductions

III. Review of October 7, 2014 Meeting Minutes

IV. Managed Care Expansion Updates
   1. Overview of expansion efforts
   2. Discussion from Plans
      a. Care Coordination Efforts
      b. Continuity of Care
   3. Active Provider Discussion

V. Open to Subcommittee

VI. 2015 Meeting Dates

VII. Adjournment

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
October 7, 2014

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

Members Present

Edward Pont, Chair, ICAAP

Kathy Chan, CCHHS

Kelly Carter, IPHCA

Alvia Siddiqi, IHC

Art Jones, LCHC

Members Absent

Diana Knaebe, Heritage BHC

Mike O'Donnell, ECLAAA, Inc.

Josh Evans, IARF

HFS Staff Present

Julie Hamos, Director

Arvind Goyal

James Parker

Molly Siegel

Jeffrey Todd

Amy Harris

Bridget Larson

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
October 7, 2014
401 S. Clinton, Chicago, Illinois
201 S. Grand Avenue East, Springfield

Interested Parties Present

Philippe Largent

Paula Dillon, Illinois Hospital Assoc.

George Hovanec

John Bullard, AMGEN

Sherie Arriazola, TASC

Ben Lazare

Marybeth Fox-Grimm, Progress Center for Independent Living

Susan Gordon, Lurie Children's

Deb Matthews, UIC-SCC

Amy Sagen, UI Health Plus

Tom Erickson, BMS John Jansa

M. Martin, PHARMA

Mikal Sutton, Cigna-HealthSpring

Ramon Gardenhire, SEIU Healthcare

Luvia Quinones, 1C1RR

Gary Thurnauer, Pfizer

Jill Hayden BCBS

Erin Weir, Age Options

Russell Brown, Maximus

Beth Hersey, Maximus

Laura Ashpole

Sharon Post, HMPRG

Gwendolyn Odom, NextLevel

Kuliva Wilburn, HMA

Sheri Cohen, Chgo Dept of Public Health

Molly McAndrew, AFC

Jeannine Solinski, University of Chicago Medicine

Diane Montanez, Alivio Medical Center

Karen Moredock DCFS

Karen Brach, BCBS

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
October 7, 2014
401 S. Clinton, Chicago, Illinois
201 S. Grand Avenue East, Springfield

I. Call to Order

Chair, Dr. Edward Pont called the meeting to order at 10:06 am.

II. Introductions

The members of the Medicaid Advisory Committee Care Coordination Subcommittee and attendees in Chicago and Springfield and those participating via telephone were introduced.

III. Review of August 19, 2014 Meeting Minutes

After a brief discussion the minutes from August 19, 2014 were approved by unanimous consent of the subcommittee. One edit was made to the list of participants.

IV. Managed Care Expansion Updates/Presentation

Mr. Parker and Ms. Harris provided the subcommittee with brief updates regarding expansion enrollment efforts. Expansion enrollment in the Metro East and Central IL regions has been largely completed. Expansion enrollment in Quad Cities and Rockford Regions is nearing completion. Mailing initial enrollment packets for expansion started in late August and early September 2014 in the Cook and Collar counties and will continue through the end of the year.

Representatives from Maximus, Illinois' Client Enrollment Services (CES) vendor, Mr. Russell Brown and Ms. Beth Hersey also participated in expansion discussion and provided the subcommittee with a presentation about enrollment practices, operations and staffing (presentation is available on the HFS website at the following link: http://www2.illinois.gov/hfs/SiteCollectionDocuments/100714_mac_ccagenda.pdf). Mr. Brown and Ms. Hersey presented information about enrollment to the subcommittee members and other meeting attendees that addressed CES call center staffing and training methods/modules, call scripts, call monitoring, quality assurance efforts, performance standards, various avenues for enrollment based on program (call center, web portal, mail, auto-assignment) and current status of expansion. During the presentation the subcommittee members and other attendees participating in discussion through sharing of questions for clarification and concerns with the CES and HFS staff in attendance. This discussion included questions regarding the Customer Service Reps approach to educating clients, handling of enrollments in FQHCs, identification of programs and health plans in available as a choice in a specific area of service, mandatory versus voluntary county enrollments, enrollment assistance for non-English speaking clients, how three-way calls and conference calls are handled, authorized rep forms,

enrollment portal, auto-assignment criteria and the importance of updated provider files from the various health plans. In addition questions regarding challenges with enrollment and concerns with enrollment were addressed in discussion between the CES staff, subcommittee members and other meeting attendees.

V. Adjournment

The meeting was adjourned at 12:05 PM.

Supplement to the October 7, 2014 meeting minutes

Report of the Subcommittee on Care Coordination provided by Dr. Pont

Dr. Pont called the meeting to order and determined via roll call that a quorum was present. The meeting minutes from August were passed unanimously with one minor change involving the attendance roll.

The remainder of the meeting focused on the Client Enrollment Broker. Mr. Russell Brown and Ms. Beth Hersey from Maximus gave a brief presentation (posted on the HFS website) and answered questions from subcommittee members and other meeting attendees.

Mr. Brown first noted the increased staffing of the CEB call center that he expected to be maintained through January. There are now 207 call service representatives (CSRs); if a call comes in after hours, clients can leave a voicemail which will be answered the next day. He also discussed training and the call center supervisory hierarchy, as well as HFS's involvement in quality monitoring.

In response to a concern voiced by Kelly Carter of IPHCA, Mr. Brown acknowledged that the FQHC enrollment is complex and presents many challenges. Ms. Carter emphasized her concern that these system issues be resolved as 35% of all HFS clients get their medical care from an FQHC. Several FQHC representatives raised similar concerns, and also clarified that all FQHC providers have a Medicaid number.

In response to a concern regarding transfer of provider files from the ACEs to Illinois Health Connect (IHC), Mr. Brown stated that Illinois Health Connect (IHC) collects the information from the ACEs and then passes that onto the CEB. Maximus passes all concerns they receive back to IHC staff. Amy Harris also added that there are weekly meetings between HFS, IHC and Maximus on provider enrollment issues.

In response to a question from MAC chair Susan Gordon, Mr. Parker again stated that HFS was working to determine what proportion of previously active PCPs have executed contracts with an MCE; at this point, however, he does not see a trend in the data. He agreed this is an important metric for the state to be following, as PCPs who do not enroll with an MCE will not be assigned patients. In response to another question from Ms. Gordon, Mr. Brown confirmed that enrollment packets for children with special health care needs should be completed within the week. Ms. Hersey also noted that if a CCE was

not operational in the client's county, the client would not be eligible to enroll in that CCE even if this severs prior clinical relationships. [Ms. Harris added in an email that a plan's providers may have offices outside the plan's zip codes or counties that clients may choose, provided their panels are open. She also noted that all providers will remain in IHC, so patients who live outside mandatory areas may still see any provider.]

Mr. Brown and Ms. Hersey also discussed the importance of accurate provider files, as well as challenges going forward regarding the lack of uniformity of data (i.e., names, office sites, etc); several attendees agreed with the importance of this issue and suggested using a unique Medicaid ID number to group providers in the database.

Amy Harris requests all questions regarding the enrollment process be directed to her (as opposed to the CEB). Her email is: amy.harris-roberts@illinois.gov She also noted that providers should also speak to their plans regarding enrollment issues.

Several questions were asked regarding rules pertaining to representation of clients during interactions with the CEB (i.e., language lines, advocacy organizations calling on behalf of a client, etc). The correct forms and procedures will be posted on the HFS website, and Amy Harris noted that Maximus can access any authorization forms sent to HFS.

Several concerns were voiced regarding the restrictions placed on physician sites and FQHCs to aid clients in choosing a plan. Kelly Carter noted that this stands in contrast to the ACA marketplace, where providers may guide their patients through the entire process. Diane Montanez also noted there was a trust issue involved, as patients had historically looked to FQC staff to help them navigate the program. Both noted that the patient population still does not understand the changes to the program, nor what their responsibilities are.

Mr. Parker replied that, even though there is no law in Illinois, HFS believes it is a clear conflict of interest to have providers assist clients in the plan selection process. Ms. Harris also referred to the guidance posted on the Department's website.

In response to a question from Patrick Gallagher and others, Mr. Parker replied that the Department is open to conversations about global panel limits but had no plans at this time; he also noted the technical difficulties in achieving this. Dr. Goyal added that there is no evidence that larger panels translate into to substandard care.

Mr. Brown discussed the enrollment process thus far. He first noted that 21% of the eligible MMAI population has opted out of the program (see presentation, page 15), 64% are being auto-enrolled. He

also noted the rollout schedule for mandatory managed care and commented that currently in Metro East approximately ⅔ of enrollees had been auto-enrolled.

FAMILY HEALTH NETWORK

MAC Subcommittee for Care Coordination

January 6, 2015

We provide access to cost effective, quality health care for people who could otherwise not afford it.
Our vision is to be the health plan of choice in our market and the leader in improving outcomes.
We honor the core values of respect, integrity, teamwork, service and stewardship.

Presentation is incomplete without oral comments

FAMILY HEALTH NETWORK

Today's Discussion

I. FHN Overview

II. HEDIS – What is it?

III. Root Causes of Low HEDIS Scores

IV. Positive Actions to improve HEDIS Scores

V. What FHN will not do to raise scores

FHN Overview

- Founded in 1995, FHN is a not-for-profit corporation directed by "safety net" hospitals with all operations located in Illinois. Historically, Family Health Network (FHN) was contracted with HFS to participate in the Voluntary Managed Care Program.

- Since 2012, FHN has been awarded contracts to serve Family Health Plan & Affordable Care Act beneficiaries (FHP/ACA), Seniors and Adults with Disabilities (SPD), Medicare Advantage (MA), Dual Special Needs Plan (D-SNP), and on the Health Exchange expanding our market from Cook County to Cook and the Collar Counties up through Rockford.

- Operational for 19 years, FHN was the only surviving Managed Care Community Network (MCCN) in Illinois. Approximately 15 MCCNs and HMOs had come and gone. We now compete against 16 new Managed Care Entities (MCE).

- FHN's model has been successful because it aligns provider incentives and results in quality care for enrollees. Providers, including hospitals, are rewarded for efficiencies and quality outcomes.

- FHN's mission is to "*provide access to cost effective quality health care for people who could not otherwise afford it."* We do so through enrollment in our health plan and also through the support we provide Safety Net Providers.

- Our Vision is *"To be the health plan of choice in our market and the leader in improving health outcomes"*

URAC 2013 Best Practices in Health Care

Health Plan Category

Gold Award

Family Health Network and Sinai Urban Health Institute, *Asthma CarePartners and Medicaid Families: Improving Health Together*

Silver Award *– Anthem Blue Cross*
Bronze Awards *– Health Care Service Corporation; BlueCross Blue Shield of IL, Northwestern University Feinberg School of Medicine, and Illinois Hospital Association*
Other Category Bronze and Honorable Mention Awards *– Aetna, Humana, Magellan, CVS/Caremark, BCBS Florida, Express Scripts…*

Past URAC awards include: a Gold Award in Healthcare Management for "Home Intervention Program" in 2008; Bronze Award for "PCP Initiative Pilot: Medical Visit after Behavioral Health Admission" in 2010; Silver Award for "PCP Initiative Implementation: Medical Visit after Behavioral Health Admission" in 2011; and Silver and Honorable Mention Best Practice Awards for the "Bridges to Health" and "Brighter Beginnings Perinatal" programs in 2012

FAMILY HEALTH NETWORK

Quality Outcomes from Disease Specific Care Management Programs

Asthma:

I. Emergency Room Visits - 76% Reduction
II. Hospital Admissions – 71% Reduction
III. “Rescue Medications” use – 53% Reduction
IV. Missed School/Work Days – 59% Reduction
V. Quality of Life – 30% Improvement

Behavioral Health:

I. Hospital Readmissions – 84% Reduction

Diabetes, Childhood Obesity, Special Needs Programs…

HEDIS

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Used by health plans and consumers to measure performance on important dimensions of care and service.
- What is your Health Plan’s HEDIS score?
- Our Network Providers deliver quality care

FAMILY HEALTH NETWORK

NCQA Health Plan Report Card

NCQA Health Insurance Plan Comparison			
	2014 Meridian Health Plan of Illinois	2014 Harmony Health Plan of Illinois	2014 Family Health Network Mean Score
Overall Score	85	72	71.5**
National Ranking Medicaid Health Plans	10/273	115/273	117/273**
Mean Performance Rating -- NCQA Percentiles			
Consumer Satisfaction (11 Measures)	4	2	3
Prevention (16 Measures)	5	3	3
Treatment (20 Measures)	5	2	2
Access (6 Measures)	4	1	1

**Based on mean performance with accreditation adjustment per FHN analysis. Total includes unranked plans.

Root Causes of FHN Low HEDIS Rates

1. Encounter Data Capture (Bad Data, not Poor Quality)
   - Capitation Reimbursement Model
   - Cumbersome and Ineffective Encounter Data System

2. Provider practice patterns
   - Education
   - Resources
   - Accountability

3. Member contact and engagement
   - Socioeconomic and demographic factors

FAMILY HEALTH NETWORK

Problematic Data Capture

2014 HEDIS Data Capture	FHN	Benchmark
Administrative Encounter Rate:	35%	80%
Medical Record Retrieval Rate:	44%	14%
• 68% of remaining sample		
Failed Capture Rate of HEDIS Data:	21%	6%

Quality Improvement Action Plan

- Conversion of 107 contracts from Capitation to Fee for Service
  - Only 2 groups refused to sign new contract
    - Includes groups with poorest HEDIS rates and administrative encounter performance
    - Continuity of care facilitated through direct contracts with affected PCPs or reassignment as needed
  - Groups required to use MSO and electronic data clearing house

- Data systems strengthened
  - New CIO December 2013
  - Dedicated encounter management/reporting implemented 7-2014
  - MSOs required to submit 837 data (to specs) for reimbursement

Quality Improvement Action Plan

- Investment in staffing and infrastructure
  - IT and Informatics: from 8 to 30 in 2014
  - Medical Quality: from 3 in 2013 to 11 in 2014
    - New Director of Quality
    - 2 new Quality Improvement Managers (total 4) and 1 Risk Manager
    - 4 new Healthcare Outreach Workers
    - 1 new Data Coordinator
  - Care Coordination: from 11 in 2013 to 17 in 2014
    - 3 new Social Workers
    - 3 new OB Care Coordinators
    - In addition to 20 Care Coordination / Outreach Staff funded by Enhanced Care Coordination Fee

(Note: FHN membership was relatively stable during these staffing increases.)

Quality Improvement Action Plan

- Provider and Group Support:
  - Monthly Operational Meetings that Include MSO Staff
    - HEDIS administrative rates and financial data review
    - Performance improvement tools and methodologies
    - Health Plan incentive programs and earning potential
  - Face to Face Engagement with High Volume Providers
    - Education and partnership on care coordination
    - Practice guideline implementation
    - Coding practices
    - Member outreach for care gap closure

Quality Improvement Action Plan

- Enhanced FFS Contract and Provider P4P
  - Primary Care Services paid at Medicare Rates (80% > Medicaid)
    - Replaces PCP Capitation
  - Preventive Service Encounter Payment ($5MM)
    - Funding made available through elimination of Direct Marketing
  - HEDIS Quality Bonus Pool ($1MM in 2014, $5MM in 2015)
    - Funding made available through elimination of Direct Marketing
  - Enhanced Care Coordination Fees to support outreach workers
    - $2 PMPM in addition to $4 PMPM base Care Coordination Fee
  - Increased member incentives for preventive care and care coordination

Quality Improvement Action Plan

- Expansion of Provider Network to Enhance Member Access:
  - 3,028 Primary Care Providers (135% increase over 2013)
  - 6,442 Specialists (66% increase over 2013)
  - 86 Hospitals (75% increase over 2013)
    - Every Safety Net Hospital
    - Rush University Medical Center
    - University of Illinois at Chicago
    - University of Chicago
    - Lurie Children's Hospital
    - Mount Sinai Medical Center
    - Presence Health
    - Advocate Health Care
    - North Shore University Health System
    - Cadence Health System
    - OSF, HSHS, Alexian Brothers

FAMILY HEALTH NETWORK

Serving Our Mission to Reduce Health Care Disparities

Actions FHN Will Not Take to Improve HEDIS Scores

1. Terminate providers serving critical access or disadvantaged areas for non-clinical reasons (e.g. poor encounter data)
   - Major Physician Hospital Organization on Chicago South side

2. Avoid providers with difficult-to-serve or high needs patients.
   - LaRabida PCMH Primary Care Physicians

3. Avoid populations with complex sociodemographic problems and determinants.
   - See next slide

FAMILY HEALTH NETWORK

Serving Our Mission to Reduce Health Care Disparities

Proportion of Health Plan Membership by Geographic Area				
	Inner City Chicago			
FHN	>80.0%			
Benchmark	<20.0%			
Member Demographics				
	African American	Latino	Caucasian	Other
FHN (2014 CAHPS Survey Respondents)	68.4%	29.8%	18.4%	19.7%
Benchmark (TMG 2014 Benchmark of Medicaid Plans)	30.0%	17.4%	60.5%	10.6%