Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
January 10, 2012

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

Members Present
Edward Pont, committee chair, M.D., IL Chapter AAP
Kelly Carter, IPHCA
Ann Clancy, CCOHF
Art Jones, M.D., LCHC & HMA
Vince Keenan, IAFP
Diana Knaebe, Heritage BHC
Kathy Chan, IMCHC
Margaret Kirkegaard, M.D., IHC, AHS
Mike O'Donnell, ECLAAA, Inc.

HFS Staff
Julie Hamos
Jim Parker
Robyn Nardone
Mike Koetting
Amy Mihalich
Michelle Maher
Laura Ray
Lauren Tomko
Tia Goss Sawhney
Erika Saleski
Ann Lattig
Aundrea Hendricks

Interested Parties
Vicki Boyle, Meridian Health Plan
John Bullard, Amgen
Christine Burnett, IARF
Lucero Cervantes, ICIRR
Carolyn Chapman, LAF
Susan Clara, Molina Health Center
Michael Cotton, Meridian Health Plan
Andrew Fairgrieve, HMA
Eric F. Foster, IADDA
Susan Gaines, IPHCA
Patrick Gallagher, ISMS
Susan Gordon, Children's Memorial Hospital
Bobbie Gregg, Du Page County HD
Dionne Haney, ISDS
Barbara Hay, FHN

Members Absent
Jerry Kruse, M.D., M.S.H.P., SIU SOM
Indru Punwani, D.D.S., M.S.D., Dept of Pediatric Dentistry
Janet Stover, IARF

Interested Parties Continued
Marvin Hazelwood, Consultant
Teresa Hursey, Aetna
George Hovanec, Consultant
Nadeen Israel, Heartland Alliance
Andy Kane, consultant
Keith Kudla, FHN
Michael Lafond, Abbott
Phillip Largent, LGS
Dawn Lease, Johnson and Johnson
M. Martin, PHRMA
Deb Mathews, DSCC
Diane Montanez, Alivio Medical Center
Tim O'Brien, Fletcher, O'Brien, Kasper, Notting
Mary Reis, DCFS
Ben Schoen, Meridian Health Plan
Jo Ann Spoor, IHA
Chester Stroyny, APS Healthcare
Deiry Velazquez, ICIRR
Matt Werner, Consultant
Brenda Wolf, La Rabida Children's Hospital

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I. Call to Order

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

II. Introductions

Committee members and HFS staff in Chicago and Springfield introduced themselves.

III. Review of November 15, 2011 meeting minutes

Margaret Kirkegaard asked for two changes. On page 4, Comments, change the last sentence to read, "Emphasis should **not** be put on some very specific indicators that are burdensome to measure …." On page 8 paragraph 5, change last sentence to read, "Like the hemoglobin A1c, it is important, but we **cannot** measure it from the claims data." The minutes were approved with these changes.

IV. Director's Report

Director Hamos advised the subcommittee that the department is moving ahead with its Innovations Project and expects to have the solicitation out by the end of next week. This is the first of a series of care coordination solicitations. HFS is pleased with the stake-holders participation thus far and is looking forward to the care coordination proposals.

The Medicaid budget is in bad shape. There is a lot of pressure for HFS and others state agencies working with Medicaid to look at ways to implement cost containment measures. There are two factors contributing to HFS' spending being over budget. One is the $1.5 billion budget shortfall that was identified last May and the other is that Medicaid enrollment continues to grow in this struggling economy. The biggest enrollment growth is with adults ages 19 to 64. HFS anticipates a $2 billion deficit by the end of this fiscal year. Between the budget shortfall and enrollment growth, the department has a very rough spring ahead of it and some tough choices to make.

V. Update on Dual Medicare/Medicaid Care Integration Financial Model Project

James Parker, Deputy Administrator of Operations, advised that the federal government issued an opportunity for states to pursue a financial realignment of Medicare/Medicaid dual eligible participants. Two financial models are available. The first is a capitated full risk model, where the state and Medicare both pay a capitation payment to an HMO to cover dual-eligibles. All Medicare and Medicaid covered services would be in the capitation payment. The other is a Managed Fee-for-Service model, where the states would manage dual eligibles under a fee-for-service structure, such as how Illinois will initially do in the Innovations Project. CMS will share Medicare savings produced back to the state.

Illinois was selected to pursue both models. The department is pursuing the Managed Fee-for-Service model within the construct outlined for its Innovations Project. When that solicitation comes out in a couple of weeks, it will invite proposals to coordinate duals in a fee-for-service model.

The feds have the dual full-risk capitation model on an extremely accelerated timeline, requiring that this model be up and running by January 1, 2013. This gives the department less than 12 months to develop and implement the model. A lot of states, including Illinois, have been pushing back that the timeline is too fast. CMS has indicated that they were rethinking the timeline, but are looking to keep a January 1st start date because of the Medicare Advantage open enrollment process. HFS hopes to know if we have the option to delay a year by the end of this week. The floor was opened for questions.

Q: Could you describe managed fee-for-service again?
A: There wasn't a lot of detail from the feds, but it sounds largely like what we will do with the Innovations Project CCE model. Payments are made on a fee-for-service basis, with an entity managing the person's care. Basically, the feds are saying if a state takes that on for duals, the savings realized by the

federal government will be shared with the state. It's not clear how the state will get the savings back from the feds or how HFS will pass that savings on.

Q: Under the managed fee-for-service model, you had envisioned getting the Medicare data for that population for entities that file to participate. Is that correct?
A: The feds had indicated early on that they would provide data, but in further discussions with them it was determined that their ability to pass Medicare data is not that good. The department does not know when it might have the Medicare data available. The feds have said that they want to share data for care coordination but you can't use it for pricing. HFS has submitted 4 letters requesting the data and each time the letters have come back asking for changes in the language.

Dr. Jones shared that some states are getting around the enrollment issue because they are making a decision to do mandatory enrollment. For example California has decided that all their duals will be enrolled statewide and are enrolling a twelfth of the population each month throughout 2013.

Mr. Parker said the feds have been clear that mandated enrollment isn't allowed in this dual model for Medicare services. It's a voluntary Medicare Advantage enrollment, with a default assignment for anyone who doesn't opt out. They have also indicated that enrollees into this dual capitated model will never have a lock-in and will be able to disenroll on the Medicare side at any time. States may, however, mandate enrollment and lock-in for the Medicaid services. The problem is what is the point of locking recipients into an HMO that only manages the Medicaid services of basically long-term care and transportation and everything else is out.

Q: The state of Michigan is doing a default and with chance to opt out. Is Illinois looking at doing that?
A: HFS is not really interested in locking in for Medicaid when you can opt out for Medicare. We are assuming that at least in some areas we will have a default in with an opt-out.

Q: The managed care companies currently have a formulary. Are you concerned with a new MCOs coming into the state because they won't have a formulary to file with this?

A: For Medicare Part D, every Prescription Drug Plan (PDP), whether a stand alone or Medicare Advantage PDP has to file their formulary with CMS annually for approval before the start of the next benefit year. That process starts in March or April. CMS is saying for the dual capitation model this time line applies, which means any plan that wants to get a dual capitation contract would have to be going through that process now. Our concern in Illinois is there's not that much market penetration here and we don't want to skew it in favor of plans already operating. We would have to get a notice out stating if you're interested in this RFP you would have to be going through the process now to be considered for a contract. We're late in doing that so there is a serious problem with the timeline.

Q: In an earlier presentation, HFS talked about integrating the 2703 application with the CCE to get the 90% federal match. Is that still the department's intent in the dual procurement that is coming out?
A: The overlap between claiming the 90% match for a CCE in the Managed fee-for-service model and getting the Medicare shared savings is not clear. But with CCEs generally, HFS expects to file a state plan to allow it to claim the 90% match on the care coordination fees, at least part of the fees for the services that are in the list, and for the people that qualify. Our priority population is broadly defined as AABD. But, the feds have clearly said on health homes you can't assume that everybody that is AABD has the two chronic conditions or a chronic condition and risk of another. So, there will be a process of identifying and flagging each person that does meet the federal definition. If the person has two of the chronic conditions we can generally identify the person through claims data. But if a person has only one chronic condition and is at risk for another, the at risk" cannot be documented through the claims. This will require the CCE to do that risk assessment and notify HFS of information on people that meet the federal definition.

HFS is also going to pursue the 90% match in the MCCN and HMO models. HFS has been talking with

Aetna, CMS and CMS' contractor about how to calculate what portion of the capitated payment in the Integrated Care Program, for instance, could be matched at 90%.

Q: Is it correct that if the condition is serious mental illness, it by itself meets the federal definition?
A: Yes.

VI. Update on Innovations Project

• Q & A from October 13th Webinar

Dr. Pont had the several follow-up questions regarding the on the department's Q&A for the October 13th Webinar.

The first relates to Question R/C 10 states: On slide 28 it states that CCEs will be transitioned to full risk MCCNs. Is that 100% certain or just a desired outcome? The HFS response was: It is an earnestly desired outcome.

Dr. Pont stated that the CCEs appear to be more a transition to a full risk product like a MCCN or MCO. This represents a fundamental change in HFS' relationship with the provider community. The response runs counter to the advice given to the July 2011 solicitation. Several provider groups, including his, stated a full risk product was not the way to go. He'd like to see HFS lay out its' rationale for insistence on a full risk model. If HFS doesn't desire movement to a full risk model, maybe it should revise the answer give to the webinar question.

Director Hamos stated that the webinar response reflects a long range desired outcome. HFS has listened to stakeholders express that, currently, full risk isn't possible and the more risk we ask of our partners the less they'll be able to do that. HFS isn't requiring a full risk model. HFS has been an advocate for the provider community by working together to develop an alternative to full risk. Director Hamos advised the subcommittee that she would be going before the legislature soon to explain what's been done since the Medicaid reform legislation was passed, at which time she will provide information on the development of the Innovations Project to build more risk into program performance and accountability.

Vince Keenan noted that with Illinois Health Connect and Your Healthcare Plus as a starting point, there will be a study coming out in the next month or so showing that the primary care case management system and some of the chronic disease management program saved not $1 billion, but closer to $2 billion. There is a good basis for saying that in a no risk environment when you do get providers involved, there is a trend towards creating ongoing savings in the Medicaid program. The CCE program creates some opportunities to build on what we have and coordinate care in a much stronger fashion. IAFP is interested in helping to get a lot of solicitations and really feels that care coordination should be based on continuing PCCM. On top of that have special projects going on in different geographic areas of the state.

Director Hamos pointed out that the Illinois Health Connect Program has not yet worked with the most complex populations. So the 14% of our population that accounts for more that 50% of the costs is a concern. Addressing this is the biggest challenge facing us for this and the next solicitation.

Dr. Pont's second follow-up was on Question R/C 11 which stated: One of the PCCM's more popular aspects with providers is the ability to regulate panel sizes. Under phase I, will this aspect of Medicaid continue? Under phase II? HFS's response was: A PCPs participation in a CCE is voluntary on the part of the PCP. The governing body of the CCE will determine whether a PCP in the collaboration can restrict its panel size.

Dr. Pont asked if this is also true for the participation with MCEs under Innovations phase II. Michelle Maher, of the Bureau of Managed Care, advised that would be negotiated between the MCE and their enrolled providers. A provider should continue to control patient enrollment and panel size.

- ***Performance and Quality Measures***

Ms. Maher advised the subcommittee that the Innovations Project would have basically the same quality measures as the Integrated Care Program, as both have similar populations. HFS is still taking suggestions on measures that would cover a broad number of enrollees. The department took the following questions.

Q: Are the specific data definitions available for the Integrated Care Program's performance measures?
A: The definitions were part of the Integrated Care Program RFP. There are a number of measures that HFS has programmed to track for the Integrated Care Program. In terms of the pay-for-performance measures or what we referred to as the "fee" or shared savings, it is a very narrow group of measures.

Q: Are those quality measures already available somewhere online for the ICP?
A: They are available on-line in the Integrated Care contract and there is also a link to the quality measures at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Documents/Perfomance.pdf

Q: Is CMS asking for a cut of the shared savings? Is that based on projected trend or current expenses?
A: The shared savings specifics haven't been finalized by CMS as yet. The concept is that if actual cost is less than the anticipated cost, the difference would be shared with the state.

- ***Status of Solicitation***

The department expects to have the Phase 1 solicitation out in the very near future.

- ***Status of Data Development***

Tia Goss Sawhney, HFS Director of Research, Data and Analytics, stated that the plan is to have data available by February 15th. The solicitation will include a letter of intent (LOI) with multiple components. HFS will ask for a description of potential care coordination organizations, asking who you are, who your partners are and your population of interest by geography, age, disability or medical condition. To get population data, the LOI will be needed early on and due by the end of February.

HFS will give a data set specific to the population; to the extent it is in our system. Persons receiving the data will be asked to let HFS know if they see any data problems and if there is something technically wrong, we'd work to fix it. There will be about a 4 month period to submit the CCE proposal.

The data HFS provides will be a limited data set, showing data by zip code and county rather than by state only. It will be de-identified, meaning it will not have recipient names, IDs or addresses. There will be provider information so that interested parties can tell who is serving the defined population. Requesters will complete a data use agreement authorizing data use for the specific limited purpose.

HFS will include a glossary of terms to define data fields and enhance understanding. Generous support from the Chicago Community Trust and Michael Reese foundation has allowed HFS to hire a technical writer. This person will be working on the documentation accompanying the data and will be the data trainer, in addition to being the point person for your questions, collecting the LOI and helping to define target populations. Director Hamos added that for the solicitation itself, HFS will not be in the position to take your phone calls. To ensure full transparency, questions must be in writing and answers will be posted on the website. Ms. Sawhney opened the floor to questions.

Q: Could we expect to see Medicare data?
A: We have asked CMS for this data but don't have as yet. It likely would take several months to obtain.

Q: HFS is providing data for 2010 only. Can data for several years be provided to see any trends?
A: HFS is committed to provide data for calendar year 2010. Depending on the number of proposals received, we may go back and look at additional years. Generally we don't have much in cost trends. Compared to health care cost trends for the U.S., Illinois' growth percentage is far lower. On a macro-basis, we don't have either per unit cost trends, nor do we have an increase in the number of units of service per

person. We have a substantial increase in persons served. The annual HFS report shows growth in expenditure of 6% but growth in population served as 6.5%. This reflects holding the line on cost and that increases reflect serving more people.

Q: Should we assume that you'll have Medicaid encounter data for the dual-eligible population?
A: Yes. We are providing the data by type of service and can show different encounters, such as inpatient behavioral health and inpatient maternal visit. Under admissions there are days and costs. For duals we will have utilization and cost but the cost is likely zero as the amount Medicare pays is often more than the state rate.

Q: Will there be cost data on persons in Long Term Care (LTC)?
A: Yes.

Q: If there is a large number of RFPs, will there any vetting of the letters of intent to ensure completeness or to encourage persons to partner with other entities?
A: HFS might encourage persons to pursue partnerships, but we are not yet sure how we would do that. Remember no one can apply alone. HFS will screen to ensure basic components are included.

Q: Regarding data, if we are covering a small population it would really help planning, reducing risk and ensuring better proposals, if bidders have 3 years of data. How can HFS assist?
A: To the extent bidders have open issues like pricing and risk, identify this in the response and leave it as something to be negotiated.

Q: How will the data be passed to bidders? Will this be LOI specific data sent to us on a CD?
A: We are still working that out. Data will be sent by either CD or File Transfer Protocol (FTP) that allows bidders to download data from a very secure website. The data we are putting out in release 1 will have three tables that include: Recipient table; Provider table, and; a smaller database table.
The recipient table will have one row per recipient and columns with information such as PCP or MCO enrollment, their age and if disabled. The table will have Chronic Illness and Disability Payment System (CDPS) flags based on the 2010 claims. HFS is setting the flags based on a publicly available risk adjustment model. It will have by type of service, the number of events and the number of units cost associated with each type of service. So for example for hospital days, the report will show the number of admissions, the number of days and the total amount that HFS paid.

The provider table will show the providers that gave services to the selected recipients. The table will show a row for each provider by name, provider type and services provided by event, unit and cost. This information will help to determine which providers should be in your network.

Users can subdivide the recipient table any way they want. For example with a very broad target population, you can subdivide the table by diabetic and non diabetic recipients. The challenge though is you cannot divide the provider table into those that served the diabetics and those who did not. HFS will try to be flexible in responding to additional data requests and will allow each bidder to get data for 2 populations. If for a particular geography you were targeting disabled adults under the age of 65, you may also want to compare information for all persons in that area and we could give you 2 data reports.

Q: Will the report also show DMH and DASA data?
A: Yes.

Q: Do you plan to post the letters of intent on the website as a way to facilitate forming partnership?
A: We don't plan to post the letters of intent, but as of yesterday we have match-making feature available on the Care Coordination website. You describe yourself and what you are looking for in a partner. This is voluntary and will not be used in any way in the solicitation.

Q: Once a bidder is awarded a proposal, will patient specific data be available on an ongoing basis?

A: Yes, patient specific data will be available to our partners. The data will be used by partners and the department to measure progress and performance.

Q: How detailed is the data going to be on the service table? Will you give us CPT, HCPCS and NDCs for drugs patients are using? Will there be service related diagnosis codes?
A: Data won't be available for these basic codes. We are running the diagnosis codes associated with the recipient through the CDPS grouper which then raises the chronic condition flags. You'll know who we think is a diabetic or has COPD, etc. We will share all flags for a requested population.

Q: Do you think HFS can provide a list of what the data categories are?
A: Yes. HFS is working on it. There is a letter on the Care Coordination website that tells about the plan to provide data at http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/DataNeedsFollowUp.aspx. Our next website communication should be the three tables and list of fields.

VII. Consumer Issues

Dr. Pont opened the topic by stating that looking at consumer issues is a charge that came from the MAC. He advised that reviewing quality measures is important but you have to make sure that people know about them. He asked how many people know that the 2010 HEDIS outcome measurements for Harmony and FHN are on the state's website and where to look for that.
http://www.hfs.illinois.gov/assets/112811_hedis.pdf

He stated that if we are going to a more consumer driven system, where persons have several choices from where to receive healthcare, they must have the information readily available in order to make a reasonable decision on which plan is best for them. Dr. Pont also noted that continuity of care is critical. He believes that by default if a person is satisfied with their provider, the system should try to ensure the person can stay with that provider. As we move forward and have potentially up to a million people to reassign, this should be kept in mind.

Director Hamos recognized the challenge for new people who have a provider now and are asked to select a different entity. They'll want to know if their provider is with one of the managed care entities. She added that Medicaid clients will have more limitations than in the past. In the short term there will be fee for service options most everywhere. In the future, networks will be serving most everybody and choice would be limited to network providers not unlike on how we select our health plans.

The department addressed the following questions.

Q: If a recipient wants to be reassigned what does the client enrollment broker consider?
A: The intent is to allow the recipient to enroll with a desired provider. The broker considers if the provider is Medicaid enrolled and if yes with what network. If the desired assignment can't be made, an alternate assignment may be considered based on existing provider relationships using claims data and consideration of providers used by other family members. Provider location, available transportation, office hours and after hours accessibility is also considered. The broker may also assist in looking for a provider that has a practice focus that fits with the recipient's medical needs. The broker does this currently and these safeguards should continue. Another safeguard is "care transition." There are certain members that you really can't transition from an out-of-network provider. Some examples include an enrollee actively engaged in oncology treatment or a pregnant woman especially closer to term. Also, if the out-of-network provider has a positive experience with patient services and timely payment, they may be willing to enroll with the managed care entity. This is a way for growth in the network.

Kathy Chan advised that the MAC's Public Education Subcommittee is a good place to discuss consumer information. As program changes happen and client notices are generated this is a committee that would

review that. The subcommittee should be involved when thinking about how to engage and empower clients to make informed decisions. Later, if we ever build a health benefits exchange in Illinois, this is information that the exchange would be making available. Later on navigators would also play a role. For now, application agents, doing enrollment and providing some basic education around provider access and available resources like website and helpline information as well as sharing computer access should be kept in mind. Agents are a resource that HFS is in touch with and with whom information may be shared.

Carolyn Chapman agreed that it would be useful to work with the Public Education Subcommittee to get information to consumers. She noted that LAF has seen hardships for recipients enrolled in the ICP to a new provider because their regular provider is not enrolled in one of the MCO networks. The concept of a provider network and making informed choices based on enrolled providers and quality measures is a new way of thinking for many of her clients.

Vicki Boyle suggested that the department develop a mini-consumer report that describes the healthcare options and quality measures. Ms. Chan shared that the subcommittee doesn't normally create educational materials, but does and will review materials developed by HFS.

Dr. Pont added that a CCE or MCO could promote strengths within its provider network like treatment of children with chronic fluid in the ears. Director Hamos agreed that HFS should support entities marketing their strengths to attract new members.

Ms. Sawhney advised that for consumers, information about quality measures may not be as important as the professional manner of the receptionist or the clinic's office hours. She sees a need for HFS to post qualitative data about our providers.

Ms. Maher suggested using patient satisfaction survey results because the plans are using the standard CAP surveys. The survey is used in the voluntary managed care programs, but not PCCM.

Dr. Pont thought it would not be best to have ratings for the individual providers but perhaps for the entity in the aggregate.

Ms. Maher added that HFS does want the Public Education Subcommittee to review all of the plan documents with us and the client enrollment broker.

VIII. Open to Subcommittee

Dr. Jones stated that one of the comments he is getting about the Innovation Project Phase 1 is the concern about the expense and slowness of voluntary enrollment.

Clarification was requested on whether or not, someone not wanting to be a MCE or CCE now, but later if HFS says there will be mandatory enrollment for a geographic area, will that person be able to create a managed care or care coordination entity? The department responded that it sees coordinated care as a rolling or continuing concept. The solicitation will likely not be the only opportunity to participate. There will be a Phase 2 where a new MCE or MCCN can participate. Mr. Parker added that the department would likely look favorably on a CCE that wants to transfer to status as a full risk MCCN.

Dr. Pont shared that State Health Facts, part of the Kaiser Family Health foundation, reported for FY 2007-2009, Illinois had the second lowest rate of average annual growth in Medicaid spending. He congratulated the state's efforts. The link to the report is: http://statehealthfacts.org/comparetable.jsp?ind=181&cat=4&sort=2292

IX. Next Meeting

For the next topic, Dr. Pont suggested looking at the managed care experience in the state of Pennsylvania because the state is ahead of Illinois on this curve and has similar geography. Pennsylvania has a PCCM model for the rural areas and 5 to 6 MCOs covering Philadelphia and Pittsburgh. HFS staff had spoke of a

similar idea of testing the capitated model in more densely populated northeastern Illinois and the managed FFS model in more rural areas of the state. He suggested recruiting two persons from Pennsylvania looking for one supportive voice and one critical voice to discuss (via telephone) their managed care experience. There appeared to be interest by subcommittee members in this topic. Dr. Pont advised that he would like to continue meeting on a Tuesday morning, but will need some planning time to set the next date.

X. Adjournment

The meeting was adjourned at 11:55 a.m.