Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
April 9, 2013

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

Members Present
Edward Pont, Chairperson, M.D., IL Chapter AAP
Kelly Carter, IPHCA
Kathy Chan, IMCHC
Art Jones, M.D., LCHC & HMA
Mike O'Donnell, ECLAAA, Inc.

Members Absent
Ann Clancy, CCOHF
Vince Keenan, IAFP
Diana Knaebe, Heritage BHC
Jerry Kruse, M.D., M.S.H.P., SIU SOM
Indru Punwani, D.D.S., M.S.D., Pediatric Dentistry
Janet Stover, IARF

HFS Staff
Julie Hamos
James Parker
Arvind Goyal, M.D.
Michelle Maher
Jeanette Badrov
Sally Becherer
Molly Siegal
Sherri Salada,
Sameena Aghi
Kerry McKenzie
James Monk

Interested Parties
Arlene Gustafson, Molina Health
Geri Clark, DSCC
Laurie Cohen, Civic Federation
Sheri Cohen, CDPH
Cathy Crumpston, DHS/DMH
Elana Dean, Urban Health Initiative
Tom Erickson, BMS
Gary Fitzgerald, Harmony-Wellcare
Eric Foster, IADDA
Paul Frank, Harmony-Wellcare
Susan Gordon, Lurie Children's Hospital
Gretchen Grieser, CCHHS
Barb Haller, IHA
Marvin Hazelwood, Consultant
George Hovanec, ARHLCH
Thomas Jerkovitz, DSCC
Mary Kaneaster, Lilly
Andrea Kovach, Shriver Center
Keith Kudla, FHN
Dawn Lease, Johnson & Johnson
Mike Lafond, Abbott
Helene Lane, Molina

Interested Parties Continued
Phillipe Largent, LGS
Randall Mark, Cook County Health Services
Jim McNamara, ViiV Healthcare
Kelley Martin, Molina
Mona Martin, PHRMA
Ana Mejia, Senior Services Associates
Susan Melczer, MCHC
Emily Miller, IARF
Diane Montañez, Alivio Medical Center
Karen Moredock, DCFS
Michael Murphy, Meridian
Jewell Oat, CBHA
Tim O'Brien, Consultant
Kristen Pavle, HMPRG
John Peller, Aids Foundation of IL
Ena Pierce, HealthSpring
Dana Popish, BCBSIL
Sam Robinson, Canary Telehealth
Dee Ann Ryan, Vermillion County MHB
Amy Sagen, U of IL Health system
Belinda Schultz, U of C Medical Center
Christy Serrano, Ounce of Prevention
Kathryn Shelton, LAF
Sam Smothers, MedImmune
Chet Stroyny, APS Healthcare
Erin Vaughan, Astra Zeneca
Cynthia Waldeck, Heartland Alliance
Matt Werner, Consultant
B. White, Forest PHM
Roxanne Walston, Senior Services Associates
Erika Wicks, HMA
Brenda Wolf, La Rabida Children's Hospital
Joy Wykowski, CCHHS

I. Call to Order

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

II. Introductions

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

III. Director's Report

CMMI planning grant

Director Hamos reported that yesterday a very interesting meeting was held to introduce a new initiative that the Department sought from the federal government's Center for Medicare Medicaid Innovation (CMMI). It is a fairly sizable 6 month planning grant. The federal government is looking for HFS to not just focus on Medicaid but to bring together providers and payers, in a multi-payer, multi-provider strategy to look at outstanding issues like service delivery and payment reform. Payment reform would be an intense undertaking if done together with all parties to see if there are ways to pay for quality and outcomes rather than for quantity.

The Governor's office is convening this effort and Michael Gelder is the project director. Health Management Associates has been retained to provide staff support. It is structured around 3 different models. These are the: "P" structure, built around our Care Coordination Entity providers; "PP" structure built around providers and plans like Managed Care Organizations along with provider groups, and; "PPP" structure built around the Cook County Health and Hospital System as a provider, payer and health plan.

After the 6 month planning period, the federal government will pick a handful of states to test the new payment and service delivery models. Even if Illinois doesn't get that, HFS can think of it as a blueprint moving forward.

1115 waiver

Illinois is interested in applying for a new federal CMS 1115 waiver project. There is not much information about it at this point but the Governor's office has signed off on this and wants the Department to move ahead. The Director anticipates that in the next few weeks a draft concept paper will be ready. It will include some themes on what the Department would do with the waiver. The process begins with the concept paper being circulated with stakeholders for some initial input. The federal government would review and indicate if it is something they would be interested in. If there is interest, the Department would really engage the community and do a lot of different analysis to determine if the project would be budget neutral which means that during the course of the 5 year project Federal Medicaid expenditures will not be more than Federal spending without the waiver.

The waiver is different from the Cook County 1115 waiver, which is more of an eligibility waiver. This 1115 waiver is more of a transformation waiver and will probably include all of our Medicaid programs and related spending. Similar to the state of New York, Illinois went through this terrible budget exercise last year and is now saving a lot of money. HFS is putting clients into managed and care coordinated care that will also save some money. The Department is saying to the federal government that we would like them to reinvest some of those savings back into Illinois for some different priorities for Medicaid clients and to give the Department some flexibility to use those dollars for programs we know we need in Illinois.

The Department will have to comb through the budget to find every possible bit of spending now and find creative new ways to get the match. HFS is not talking about using the existing program match dollars but there are things in the HFS budget that if the federal government let us be more flexible we could match federal dollars to bring into Illinois under this 1115 waiver.

Q: There have been some concerns that the move to managed care could somehow affect the federal match

we get as a result of the hospital provider assessment. Is this 1115 waiver being done to address some of those concerns and the federal match relative to that assessment?

A: As part of our hospital rate reform work and nursing home rate reform, what the Department knows is that part of the hospital assessment dollars are going to be above what is called the upper payment limit in about a year and a half as more cases go into managed care. The waiver does allow HFS to adjust for that.

IV. Budget Update

Director Hamos reported that she did not yet have a good sense on how the budget was going to work out. The Governor introduced his budget and it has been relatively quiet since then. There have been meetings before the various appropriations committees. HFS has been presenting a little on the budget. There have been some questions from advocacy and provider groups about the SMART Act and utilization controls from last year. The legislature is looking at what is doable and if any of those items can be restored.

V. Review of October 2, 2012, January 8, 2013 and February 5 meeting minutes

Since there was not a 6 member quorum, the minutes could not be approved.

Dr. Pont asked for clarification on the minutes from the January 8th meeting page 2. He understands that children with complex needs would be in care coordination but wanted to know if it is correct that children with no complex medical needs would also be placed in care coordination...

James Parker, Deputy Director of Operations clarified that all children in the regions with managed care would eventually be enrolled in care coordination. The regions include greater Chicago, Rockford, Quad Cities, Metro East and Central Illinois. Director Hamos added that since 1.6 million of the 2.7 million Medicaid enrollees are children, it would be necessary to enroll children to meet the state mandate that 50% of recipients be enrolled in a coordinated care system by 2015.

VI. Attendance - Quorum

There was concern about committee member attendance. There has not been a 6 member quorum for the last three meetings and only 5 committee members were present at this meeting. Dr. Pont noted that Dr. Kirkegaard has resigned from the committee leaving a total of 11 committee members. He advised that he would discuss member attendance with HFS staff offline.

VII. Update on Care Coordination Project

Mr. Parker provided the update.

a. Complex Children
The Department has received 7 proposals in response to the CCE for children with complex medical needs solicitation. There were 5 proposals from the Chicago area, 1 from Peoria and 1 from Macon County. The Department has completed preliminary reviews and high level summaries. HFS hopes to announce awards by the end of May.

b. Dual Medicare/Medicaid Care Integration Financial Model Project
The Department and MMAI awardees are working hard toward implementation. The Memorandum of Understanding (MOU) is out on the HFS website. The Department has received questions and is renewing the stakeholder's process. People may have received an email from the Director announcing the first meeting later this month. Invitations were sent to about 2,600 people. HFS will be having those meetings every other month. The focus at this next meeting will be on the enrollment process. There will be discussion on outreach and education to smooth the way for rollout to the dual-eligible population. Director Hamos added that people may have received a second invitation that asks that people pre-register for the meeting in order to plan for the meeting space.

The Department recently received a federal document about the enrollment process. HFS is working through this document along with Maximus, the Department's contracted enrollment broker. Health plans continue to build their networks and providers should be hearing from them. Mr. Parker encouraged providers to contact him if they haven't heard from the health plans.

c. CCEs
HFS had made awards to CCEs last fall. The Department is working with the CCEs to get them up and running and particularly with the Macon County and Precedence CCEs so they are ready when HFS goes forward this summer with the mandatory enrollment of the Seniors and Persons with Disabilities population that are not dual eligible. HFS is very pleased with the CCE's efforts. HFS is grateful to have HMA helping to get the CCEs ready and appreciative of the work of Molly Siegal, the Department's CCE project manager.

d. CMMI
Mr. Parker referred to the Director's report on the new initiative from the federal government's Center for Medicare Medicaid Innovation (CMMI). Director Hamos added that the project in Illinois is called Alliance for Health. She added that the Governor's Healthcare Reform website would be updating information at: http://www2.illinois.gov/gov/healthcarereform/Pages/default.aspx .

VIII. Continuity of Care

Dr. Pont stated that that there is a historical change coming to the Medicaid program. In 2014 about 1.4 million Illinoisans' will be moved from their current model of health care to a multi-payer model. He advised that the challenge going forward is to make sure this process occurs as smoothly as possible.

Dr Pont referred to the University of Illinois at Chicago report that evaluated results from the first year of the Integrated Care program. The report showed no significant change in unmet need for enrollees so that patients are essentially receiving the same care. The report showed that member satisfaction has gone down so there more people that are less satisfied. Claims from out-of-network providers were close to 50%. The initial auto assignment rate was high at 70%. A significant number of people were taken from their medical home. He noted that this is bad and that we should not simply blame the providers but think of ways we can better work together. He offered 4 policy suggestions that are shown below with some of the group discussion.

1. **HFS should be more proactive and identify plans serving the different PCP panels and those people that will need to be moved. HFS should provide information to the individual practices as to which plans patients will be enrolled during 2014.**

Brenda Wolf commented that La Rabida Children's Hospital had been auto-assigned patients that staff have yet to find.

2. **The Client Enrollment Broker (CEB) process must be robust to provide options to enrollees and facilitate new enrollees staying with their desired PCP. It must contain current information regarding the plans' provider networks to minimize any inadvertent disruption in continuity of care.**

Mr. Parker stated that there is a roll-out schedule by population type for when HFS will be moving people. It shows a begin date but each process will happen over 6 month or more. There is also a cap on the number of persons that can be assigned to a provider.

He explained that when HFS goes to mandatory enrollment, persons will receive an enrollment package explaining the options in their region. They have a 60 day period to make a choice. The first letter gives the

individual 30 days to choice a plan. The enrollment letter encourages the person to call the CEB. The telephone script directs the CEB to discuss the current PCP assignment and what hospital is of interest. If no choice is made, a second letter is sent. If no response, the person is auto-assigned. The process has an algorithm using the current PCP information to make the assignment to the plan their provider is affiliated with. It is important that providers sign up with a plan.

Mr. Parker explained that initially there was a lot of provider resistance. The Department and MCOs needed to look at where providers were philosophically. HFS anticipates that enrollment will be easier than in the PCCM start-up which was a wide open process. Now most children have PCCM assignments.

Dr. Pont suggested that the Department work with the state medical society to help with providers having panels of 200 – 250 patients to help ensure continuity of care.

Keith Kudla stated that the Department is concerned about network adequacy before rolling out a plan. This has been his experience with the Community Care Alliance in the Rockford area. A first step is to get information on the providers in a region to facilitate outreach.

Dr. Art Jones asked how difficult it would be to create enrollment package letters that show the assigned PCP and the plans they are enrolled in as a client wants to keep their PCP and join that network.

Mr. Parker responded that the PCP name and plan information is available but the Department wants the client to call the Client Enrollment Broker to discuss options.

Dr. Jones pointed out that the high default level has been a problem.

Mr. Parker responded that a large number of physician practices are owned by hospitals. Individual providers may say that they do not enter into the contract and that the plan representative must speak with the hospital.

Kathy Chan stated that she would be interested in the level of auto-assignment. She asked if there is patient satisfaction survey.

Mr. Parker didn't know if CSG is doing a client survey but auto-assignment is tracked. He believed that UIC is looking at those types of issues.

3. **There are patient populations that are generally low-risk, for whom the risk of disrupting continuity of care is outweighed by the advantages of care coordination. For those populations, a fee-for-service option should exist *if the PCP is not in the plan to which the patient is assigned***

Dr. Jones stated that a problem with not enrolling the low risk individual is that you want to know as soon as possible when the person moves from low risk to a higher level of care.

Another person added that ancillary services may be needed for a family but not available if left out of coordinated care.

Dr. Arvind Goyal, the HFS medical director stated that care coordination allows for some risk on the part of the provider. It is something to think about more. If a child is assigned and there is a change in the level of risk, there can be some modification after assignment. Assignment doesn't have to be a burden.

Dr. Jones recommended that the PCP that is concerned about continuity of care should sign up for at least one MCO so the patient may be auto assigned to them if no choice is made. There may be a problem that the PCP will take current patients but doesn't want new Medicaid. This can be addressed.

4. **HFS should work with providers to build a robust specialty care network by encouraging plans to appropriately reimburse specialty care. Access to specialty care will entice providers to join creating a "win-win" situation for Medicaid patients. Care management should be in cooperation with providers, as this is the best way to improve care coordination.**

John Peller stated that he is concerned about access to medications. What medications are on the plan formulary? Will that be taken into account?

Mr. Parker stated for MMAI the plan formularies are basically the same as for Medicare Part D. The plan pays for the drug the person was taking beforehand. He believed the transition period was 90 days. Coverage of AIDS drugs is likely comprehensive. For the Integrated Care Program, HFS reviewed the formulary to ensure it includes the same class of drugs as under Medicare Part D. The plan formularies were very close to the drugs coved under Medicaid.

One participant noted that things went OK with ICP but she has some concern with a larger number of enrollees. It can be a little difficult to find the formulary online.

Ena Pierce stated that there is information that HealthSpring would like to put on their website but is waiting for direction from the federal CMS. She stated that regarding the formulary the standard for Medicare Part D will apply.

IX. Common Goals from Plans

Ena Pierce stated that the MMAI plans have met twice and discussed standardizing billing information. They started by looking at how Aetna and IlliniCare have coded claims. The group would like a homogenized list of code sets for billing. The group is also looking at billing code standards for long-term care. The goal is to create one uniform document that is put in one place with a consistent set of tools. There is an opportunity for a subset of providers to have a uniform set of procedures. She added that prior approval guidelines are a special situation but it may be another place to look for some commonality.

Dr. Jones stated that other ideas for common goals for the plans are: Standardized credentialing; Common care plan platform mainly for care managers, and; Determination of need, should data be available to health plans.

X. Out Patient ER Usage

Mr. Parker referred to the handout, "ER Use Before and After SMART Act – by Age" that was included in the meeting notice package. He explained that the charts show monthly ER usage in the period from July 2011 through December 2012. He noted that the data for the most recent months may not include all the ER encounters. The charts show the number of total visits by type and an adjustment for visits per 1,000 enrollees. The data had been requested at previous meetings. He also referred to meeting notice a handout, "December 2012 ER Spike Check that compared ER visits by service type for November and December 2012.

Dr. Jones stated that an encouraging part of the Integrated Care Program is the reduction in ER utilization by 6% and an 18% reduction in hospitalizations.

Dr. Jones and Dr. Pont identified the jump in ER visits in December for acute upper respiratory infection and influenza as a reflection of the outbreak in influenza in that period.

XI. Open to Committee

Dr. Pont asked for suggestions for topics for future meeting. He stated that there had been some interest in having presentations on Electronic Medical Records (EMR) and the Health Information Exchange (HIE).

It was suggested to invite Laura Zaremba with the HFS Office of Health Information Technology and Raul Recarey, Executive Director of the Health Information Exchange Authority.

Director Hamos suggested looking at what the Illinois Health Insurance Market Place staff is doing to roll-out the exchange.

Mr. Peller asked if the Department could provide feedback on the comments it had solicited on the Health and Quality of Life Performance Measures.

Ms. Wolf commented that there is a need for education for PCPs to understand the Department initiatives and what is needed to make them work.

Based on the group discussion, Dr. Pont advised that he would like a presentation on the Health Information Exchange at the next care coordination meeting.

XII. Next Meeting

The next meeting is scheduled for Tuesday, June 11, 2013 from 10 a.m. to 12 p.m.

XIII. Adjournment

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