ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

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Memorandum

DATE: September 21, 2012

TO: Members of the MAC Care Coordination Subcommittee

FROM: Julie Hamos
Director

RE: MAC Care Coordination Subcommittee Meeting

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The next meeting of the Medicaid Advisory Committee's Care Coordination Subcommittee is scheduled for Tuesday, October 2, 2012. The meeting will be held via video-conference from 10 a.m. to noon. Those attending in Springfield will meet at 201 South Grand Avenue East, 3rd floor video conference room. Those attending in Chicago will meet at 401 South Clinton, 7th floor video conference room.

Attached, please find the agenda for the meeting, the minutes from the January 10 and June 20, 2012 meetings, an Outpatient Emergency Room Usage spreadsheet, and information on three guest speakers arranged by Chairman Pont and HFS; Dr. Margaret Kirkegaard, Cheryl Lulias, and Robert Mendonsa.

As part of the Department's ongoing efforts to reduce administrative cost, copies of the material will not be available at the meeting. Participants should plan on bringing their own copies.

This notice and the agenda have also been posted to the Department's Web site under MAC Meeting Notices:
http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommisions/MAC/News/Pages/default.aspx

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

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

October 2, 2012
10 a.m. – Noon.

Agenda

I. Call to Order

II. Introductions

III. Director's Report
– Budget Update

V. Review of January 10 and June 20, 2012 Meeting Minutes

VI. Update on Duals Project
– Status of Solicitation
– Dual Medicare/Medicaid Care Integration Financial Model Project
– Care Coordination Entities

VII. Preventing inappropriate ER use with Care Coordination
- HFS Spreadsheet
-Dr. Margaret Kirkegaard
- Cheryl Lulias
- Robert Mendonsa

VIII. Affordable Care Act and the Future

IV. Open to Subcommittee

X. Next Meeting

XI. Adjournment

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

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

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.

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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.

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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.

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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.

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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.

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
June 20, 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
Diana Knaebe, Heritage BHC
Kathy Chan, IMCHC

HFS Staff
Julie Hamos
Robyn Nardone
Michelle Maher
Greg Wilson
Pam Bunch
Andrea Bennett
James Monk

Interested Parties
Amanda Attaway, ISMS
Mary Ellen Baker, MedImmune
Marlene Blackwell, Conceptus
Hillary Bray, Access
Debbie Broadfield, IADDA
Chris Burnett, IARF
Carrie Chapman, LAF
Lea Cizek, Addus Healthcare
Geri Clark, DSCC
Sue Clark, Molina Healthcare
Cathy Cumpston, DHS/DMH
Kara Curtis, HCSC/BCBS of IL
Deila Davis, Access
Andrew Fairgrieve, HMA
Neil Flynn, Flynn Law
Jill Fraggos, Lurie Children's hospital
Susan Gaines, IPHCA
Katie Galle, Meridian Health Plan
Susan Greene, SGA
Michael Groban, M.D. WellCare
Barb Haller, IHA
Barbara Hay, FHN
Justin Hayford, AIDS LCC
Marvin Hazelwood, Consultant
Brian Hedinger, Jazz Pharmaceuticals
Nadeen Israel, Heartland Alliance
Nicole Kazee, U of I Health System

Members Absent
Kelly Carter, IPHCA
Ann Clancy, CCOHF
Art Jones, M.D., LCHC & HMA
Vince Keenan, IAFP
Jerry Kruse, M.D., M.S.H.P., SIU SOM
Indru Punwani, D.D.S., M.S.D., Dept of Pediatric Dentistry
Margaret Kirkegaard, M.D., IHC, AHS
Mike O'Donnell, ECLAAA, Inc.
Janet Stover, IARF

Presenters via conference call
Jamie Calabrese, M.D., Gateway Health Plan
Kyle Fisher, Penn. Health Law Project

Interested Parties Continued
Judy King, M.D.
Azmina Lakhani, SGA
Derek Lanier, Meridian Health Plan
Phillip Largent, LGS
Grace Martes, Molina Health
Mona Martini
Kevin Mc Fadden, Astra Zeneca
Susan Melczer, MCHC
Diane Montanez, Alivio Medical Center
Karen Moredock, DCFS
Heather O'Donnell, Thresholds
Debbie Pavick, Thresholds
Jennie Pinkwater, IL Chapter AAP
Jay Powell, AmeriHealth Mercy
Mary Reis, DCFS
Julie Ross, Abbott Diabetes Care
Joel Roth, U of Chicago Medicine
Phyllis Russell, ACMHAI
Susan Sommers, HCSC/BCBS of IL
Margaret Stapleton, Shriver Center
Bernadine Stetz, Molina Healthcare
Rebecca Thompson, Progress CIL
Matt Werner, Consultant
Sarah White, Abbott
Brenda Wolf, La Rabida Children's Hospital

Illinois Department of Healthcare and Family Services
Care Coordination Subcommittee Meeting
June 20, 2012

I. Call to Order
Dr. Pont called the meeting to order at 10:00 a.m.

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

III. Director's Report
Director Hamos reported that it had been a very painful legislative session with some very serious work in developing a plan for $1.6 billion in budget reductions. This is something that no state has ever had to do on this scale. It was a big challenge to do and will be a bigger challenge to implement. There was an attempt to look at providers for whom we were concerned to maintain access for our clients. As a result there are no great cuts for physicians, FQHCs, dentists, safety-net hospitals and rural access hospitals.

HFS must file rules as part of the Save Medicaid and Resources Together (SMART) act by the end of the month. Greg Wilson stated that in order for implementation, the proposed rule changes need to be filed 10 days before the effective date. HFS would also be filing permanent rule changes at the same time. Director Hamos added that there would be a 45 day comment period for the permanent filing. The SMART act link is http://www2.illinois.gov/hfs/agency/Pages/Budget.aspx - proprules

IV. Guest Speakers – The managed care experience in Pennsylvania
Dr. Pont had suggested looking at the managed care experience in Pennsylvania as this state is going down a similar path as Illinois in introducing managed care and has similar geography. Illinois is likely to have more managed care in heavily populated northern Illinois and the PCCM model would likely be more prominent in the less populated regions. Pennsylvania has a PCCM model run by Automated Health Systems covering the rural areas and 5 to 6 Managed Care Organizations (MCOs) covering Philadelphia and Pittsburgh.

Dr. Pont introduced Dr. Jamie Calabrese, Medical Director of Gateway Health Plan, Pittsburgh, PA and Kyle Fisher, Pennsylvania Health Law Project, Philadelphia, PA. He asked that each guest share their experience with managed care, identifying what works and what may be improved upon. Participants would be encouraged to ask questions afterward.

<u>Dr. Jamie Calabrese comments</u>
Dr. Calabrese began by reviewing that in the Philadelphia and Pittsburgh areas, the delivery system went from fee-for-service (FFS) to a managed-care model with different plans competing for business. The current plan is to go into rural areas starting on July 1 in the 7 counties near the Harrisburg area. Other counties in the western part of the state are expected to come on September 1 and the eastern part of the state by March next year. The entire state will be using MCOs by next year.

There are 9 MCOs in the state. Not all compete in all geographic areas. Gateway is providing coverage in several parts of the state. Evaluating the transition from PCCM to MCO depends on your perspective. From the health plan and budget perspective, the transition has been very good. A health plan study for the state found there would be a potential savings of $2 billion if the whole state went to MCOs.

For a health plan, growth is good but also painful. The plan needs to have a network of providers in place before it can compete to get access to the counties. This can be a lot of work without the plan knowing if they will get anything out of it. The state will then set the payment rates and the plan must decide to work with the rate or bow out. With the plan having a lot of investment before the bid, it is not often that an MCO would back out based on low rates.

Rates have a down flow effect. The MCO can only give providers what they get from the state. Gateway pays providers a capitated rate and some providers will balk saying they will lose money. Sometimes additional analysis is needed. For example, the hospital in Pittsburgh said they were losing money. Gateway reviewed a year of their claims data, calculating what they would have paid as fee-for-service (FFS). The review found that the hospital was 25% better off being in a capitated payment model.

For doctors, the only way to tell if they're better off under FFS versus capitation is to sift through the numbers. Some doctors are happy with capitation as there is a steady monthly payment. Some providers are happy that there is a state funded children's vaccine program as vaccines can be costly upfront to purchase.

Pediatric specialists feel the most short-changed and they probably are as the state rate is lower than the commercial rate. The specialists expect to earn more than the primary care doctors. They don't get a lot for consultations and surgeons don't get a lot for surgeries. That's just the reality. It is a balancing act. While no one is forced to work in the Medicaid program, the Medicaid managed care plans like Gateway have to be competitive enough to maintain a provider network. Managed care is advantageous for our members because of the care management and disease management programs. These are not provided under FFS. Our services that are above and beyond paying for visits save money and improve health outcomes for our members.

Pennsylvania is one of a few states that offer "family of one" provisions. A child with special healthcare needs is eligible for Medicaid regardless of family income. This makes a huge difference for middle class families in getting therapy, medical equipment, skilled nursing care and private health aides for children.

Our biggest frustration is that we have separate physical health and behavioral health MCOs for clients. The rules are such that we can't interact with each other or know what members are doing. Gateway is responsible for all pharmacy including psychotropic drugs that psychiatrists write for our members. However, the psychiatrist can't find out if the prescriptions are being filled and we can't find out why the drugs are being prescribed.

<u>Kyle Fisher comments</u>
The Pennsylvania Health Law Project (PHLP) is a state-wide legal services organization fielding roughly 3000 client calls per year. It serves as counsel to the consumer subcommittee of the statewide MAC and meets monthly with the state on the Medicaid program. This gives us both a policy and an individual case perspective on Medicaid managed care. Pennsylvania currently has the PCCM model in 42 rural counties. That is being phased out. Mr. Fisher provided some cautionary comments about risk-based managed care.

In Medicaid managed care, there is a business ethos introduced in negotiating rates for care that is different from the normal ethos around hospitals and providers accepting Medicaid patients. Under PCCM with FFS payment, a provider looks at the rate and decides whether or not to accept patients. This is not the case when you have a private entity coming in as a third party and being paid a capitated rate. We routinely see contract disputes between MCOs and hospitals which can disrupt care for clients and cause confusion. We expect to see more of this in the rural counties going forward with a statewide managed care model.

PHLP sees the MCOs using recipients as leverage in their contract negotiations. The largest MCO that dominates the market for Medicaid is currently negotiating contracts to recruit PCPs with the 3 area hospital systems. The process has been stalled for 6 months. One is a large prestigious academic health system stating it isn't going to assign patients to its members until there is a rate agreement. This has affected the hospital's bottom line as it hasn't been able to get patients from that MCO for 6 months. This has limited choice for consumers and is contrary to best serving Medicaid recipients.

The MCOs' interest is aligned with the state over consumer interests when enrollment is frozen. An MCO felt it was experiencing adverse selection by getting the sickest members. As a remedy, the plan took no new members for 9 to 12 months and new members were assigned to the 2 other MCOs in the service area. This enrollment freeze limited consumer choice. As the state moves to more mandatory managed care, the program is promoted as increased choice through competition. Potential cost savings is not being promoted.

Another issue is the suitability of managed care in rural areas. The state offered voluntary managed care in some 17 to 25 of the rural counties that had the PCCM model. The voluntary MCOs had very little enrollment and were unable to build a very large provider network. Gateway Health Plan decided, after 3 straight years of financial losses, to pull out of 17 counties. Some recipients lost their connection to their doctor as they were not accepting fee-for-service Medicaid patients.

PHLP routinely sees service denials that it believes may result from the MCO trying to save money at the expense of patient care. To recruit more providers, MCOs may pay more than the fee-for-service amounts. If the state is paying the MCOs less yet doctors are being paid more, then savings have to come from somewhere. Plans have to consider cost and the claims that providers are submitting. Mr. Fisher believes the savings are coming from utilization review. PHLP regularly sees this in service denials. It is frustrating as PHLP often sees cursory denials like "not medically necessary". There is a need for state oversight. PHLP is concerned that as the state agency shrinks there are not enough state employees overseeing the utilization review by the plan to ensure that service denials are not done inappropriately.

Q: What did Pennsylvania do regarding continuity of care when voluntary managed care enrollment is low (about 15%) and the state is moving from a PCCM model to a MCO dominated model in urban areas and MCO blend in the rural areas? What strategies were employed? Are there any statistics about how many people had to find a new provider because of an insurance switch?

A: Dr. Calabrese was not aware of any data about persons forced to find a new provider but stated that the consumer has the upper hand with at least 3 MCOs competing in every county. The consumer could look at the panel of doctors that each MCO offers. If the doctor allows FFS Medicaid, they likely have at least one MCO contract. There should be little disruption, at least at the primary care level.

When Gateway first goes into a county, they see a lot of non-participation authorizations to ensure continuity. As the MCO becomes established, you see that number go down. Gateway will approve out-of-network care to maintain continuity. If there's a conditional that is particularly complex the MCO will continue that non-participating care indefinitely. The mantra is to do what is right for the member.

Gateway pulled out of 17 rural counties as it wasn't getting significant volume. There wasn't motivation for members to enroll in a capitation plan requiring them to get prior authorization to see a specialist when the FFS choice didn't require that. With MCOs competing against MCOs the playing field is much more level.

A: Mr. Fisher pointed out that with medically frail patients having multiple providers it is less likely that all their providers will be enrolled with an MCO. Pennsylvania does have some continuity of care rules in place. The state allows 60 days to find another provider for patients that have an established relationship with a non MCO enrolled provider and encourages the MCO to recruit that doctor into its network.

Q: Dr. Pont asked about special needs children getting service and the Special Needs Units (SNUs).

A: The Gateway health plan has nurses and social workers in the SNUs. Every child's status is reviewed at least once a year and often more frequently. There is a care coordination conference to look at what a child needs and what services they are getting. They will analyze why there may be multiple hospital or ED (Emergency Department) admissions, asking what they can do for the high cost child both to reduce cost and improve care. The approval rate for service requests is one of the highest in the company.

Q: Is there is a separate MCO handling a child's mental health needs?

A: Unfortunately, there are separate behavioral health MCOs. When these kids have behavioral health issues, we can tell only by seeing their medication profile. We ask the parents if they'll talk to us. All we can do is see if we can help the child get into the behavioral health system in a better way. We don't know if the patient is taking the meds or if their PCP is prescribing the same meds.

A: Mr. Fisher agreed that Gateway does a good job with special needs children but that is not necessarily true across the board with other MCOs. Some plans visit a child, while others may only initiate telephone contact. It's best to ensure that care coordination responsibilities are spelled out in the MCO contract.

Q: Is there a way to ensure that enrollees go to their assigned health plan providers? What happens when an auto-assigned recipient goes to a provider outside the network?

A: Dr. Calabrese used the example of a parent taking their child to a doctor with whom the child has an established relationship rather than to the MCO assigned doctor whom the child has never seen. The doctor will likely find that the child is not on the membership list and say either you could change to me or I'll try to get a pre-authorization for the current visit. The plan often approves the out-of-plan payment once to allow for a PCP change. If the child is not in network and it is not an emergency, the child may be turned away. There is no obligation to see the child.

Q: Is there a different capitation rate for the special needs children? If not, isn't it counter-intuitive to pursue special needs children for enrollment?

A: There is not currently a risk adjusted capitation payment, but we are working on it. Gateway has a dual-eligible contract with a rate adjustment for Medicare services. We're looking at using the same model in our Medicaid business.

A: Pursuing special needs children for enrollment is more a hardship for the provider as it is the same per member per month (PMPM) amount regardless if the child is healthy or special needs. Gateway gets back some reimbursement from the state to partially cover our nursing hours, medical daycare and home health aides. We have learned to manage it and its' part of our mission to care for the poor and indigent sick.

Q: Is there is a lock-in period where you must stay with the MCO for a year?

A: There is no lock-in period. The individual could change every month.

Dr. Pont added that he was initially very concerned when the Illinois PCP edit was turned on that persons would be going to the wrong doctor. Through a stakeholders' meeting and data provided by Dr. Kirkegaard, the notion of enrollees running from doctor to doctor wasn't as big a concern as initially thought. Dr. King's point is well taken that people are used to going to the right doctor under PCCM. The challenge going forward to a Medicaid managed care model is to ensure there is as much continuity of care as possible.

We want to ensure to the extent we can that when a patient is switched to an MCO that this change is accepted by the physician. There is another layer that when the health exchange comes on board we will have people switching back and forth from the commercial insurance world to the Medicaid world. It will be important to ensure continuity of care for those members. Dr. Pont was pleased that the department's Bureau of Managed Care also saw this as an important issue.

Dr. Calabrese added that churning for persons that hover around the top of the eligibility cut-off is a big issue in Pennsylvania as well.

Q: When a patient seeing a doctor every 3 weeks is moved to a capitated program and the regular doctor is paid less than under FFS, would the doctor reject a patient because they will be paid less?

A: Gateway doesn't see that. The counter argument is that the provider is paid monthly for a healthy child that may only be seen once a year. The individual doctor must look at the whole package and realize in the long run they are making a profit. The University of Pittsburg hospital PCP panel, representing 36 large practices, found that they came out about 20% ahead in the capitated model.

Gateway's PCPs are paid on a capitated basis. Most hospitals are on DRG (Diagnosis-Related Group) payment, although some are per diem. Specialists are paid fee-for-service.

Q: Dr. King asked if the state funded vaccine program include adults. What have you seen in terms of any changes in the quality of care people are receiving, utilization and customer satisfaction?

A: The vaccine program is VFC (Vaccine for Children) and covers only children up to 21 years of age. There is no equivalent program for the adult population.

A: Dr. Calabrese believes that the managed care service quality is better than FFS. Gateway credentials all their enrolled physicians and has been told that the standards are tougher than for most commercial plans. Under the "Gateway to Physician Excellence" program, we put out quality measures at the beginning of the year and pay at the end of the year to incentivize quality care. If a pediatrician's patients are getting immunizations, well exams and a strep test before getting antibiotics, you'll get an extra check from Gateway at year's end. In the adult world, if the provider is doing PAP smears, screening for colon cancer and all the usual adult well-care, there is also an annual bonus payment.

A: Mr. Fisher stated that in looking at HEDIS data for the PCCM and Managed Care programs, the data was comparable and the quality was relatively the same. From a consumer satisfaction perspective, the PCCM program scored slightly higher but not a great difference.

Q: Do you see an integrity issue in a capitation model for PCPs where a provider will game the system to do the best they can to collect the capitation check which will far exceed the amount of care they're giving and render the quality measures tangential at the end of the year?

A: Dr. Calabrese stated that some people out there may do that but would disagree about reimbursement. If the provider is not giving the vaccines and EPSDT service, they won't get the incentive check.

A: Michelle Maher, Chief, Bureau of Managed Care, added that in the HFS Integrated Care program there is a risk adjustment done at the end of the year based on the level of need of the client. There are 2 health plans in the program. If the department determines that sicker clients pick one health plan while the health plans are paid the exact same rates throughout the year, at the end of the year the department's actuaries will adjust

the rates retroactively to cover the sicker caseload. It really doesn't behoove either plan to try and get the healthier people as the rates will be adjusted accordingly.
Q: Dr. Groban commented that in terms of fee-for-service versus capitation for PCPs, it seems that the response in Pennsylvania is much more favorable than what we have for certain pockets of our state. The question is whether or not this incentivization or augmentation at the end of the year is the way to go.

A: Dr Calabrese stated that Pennsylvania has not yet got to risk adjustment on their Medicaid business but thinks it is probably a better model. She believed that if there is adverse selection by a health plan, it is driven by the doctors in the community and the plan has to find a way to deal with it.

Dr. Pont added that at least the downside risk is minimized in Pennsylvania.

Q: A behavioral healthcare provider asked about the response of the MCO as you enter rural areas where there may not be the full array of services available to meet EPSDT standards?

A: Dr Calabrese stated in Pennsylvania there is a huge lack of adolescent and pediatric psychiatry. The Behavioral health MCOs are starting to do some telemedicine for child psychiatry. As an MCO, we have to have a network that can provide EPSDT services or we cannot work or compete in that county.

V. Review of January 10, 2012 meeting minutes

Dr. Pont stated that he didn't find the January meeting minutes included with the meeting agenda posted online. He suggested that the subcommittee table the review of the minutes until the next meeting.

VI. Update on Innovations Project

Director Hamos stated that the submittal deadline for the Innovations proposals was last Friday and 20 proposals were received. Some covered more than one area.

The submittal deadline for the dual-eligibles proposals was yesterday and 9 proposals were received. The department is working with the federal CMS on what the financial model will look like.

The Innovations project was launched on October 13 because the department wanted to give lots of time to providers to organize themselves. Right after that, the federal government launched the dual-eligibles project with very strict deadlines which are now somewhat changing. We had 2 things that came in almost the very same day. The dual-eligibles project that MCOs and MCCNs have applied for will take first priority as we are dealing with the federal government as well. After that, we'll come back to the Innovations project and hope to launch some of them by the beginning of next year.

A behavioral health provider commented that in looking at our data for the Innovations piece, 40% of their specialty population was dual-eligible. MCOs were shocked that a large portion of their potential population were receiving behavioral health services.

Director Hamos asked for feedback on the client data the department had shared with potential bidders. She advised that HFS was interested in putting out a survey to the proposers to improve its data sharing capacity. She noted that data analytics is an important part of HFS' mission. The department wants to learn from this and to ensure that HFS providers have the data for which both of us will be held accountable.

One person advised that the data was better than initially expected. It gave some good broad pictures of populations. The flags were useful but at times the data was hard to compile and cross-reference, in particular, the flags for pharmacy and diagnosis issues.

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VII. Open to Subcommittee

Dr. Pont asked for ideas on what this subcommittee should be doing. The mandate from last March that created the subcommittee was pretty broad so any topic could be considered as a subject for a meeting. There was robust discussion on potential topics and several were identified.

- A meeting on care coordination to prevent inappropriate ER use. Dr. Groban was concerned that the $1.6 billion in savings identified by the state may really be less cost savings but more a cost shifting by driving care to emergency rooms.

- If the Supreme Court upholds the ACA, the department will expect to see 500,000 more Medicaid recipients in Illinois and it is likely that all persons added will be in care coordination. Director Hamos suggested that an interesting subject for discussion is where are the providers who are going to take this big new caseload. What might the providers and the offices and clinics of the future look like and do?

- Susan Greene suggested a presentation about the CCEs (Care Coordination Entities) that are chosen that could include a brief synopsis of their plans.

It was asked if HFS would publish the names of the entities that had submitted proposals for the CCE and dual-eligible contracts. Ms. Maher and Director Hamos advised that yes the names and addresses would be published this week on the care coordination website.
http://www2.illinois.gov/hfs/publicinvolvement/cc/Pages/default.aspx

Katie Galle asked about the next RFP for MCOs it was understood that the RFP would be released in late summer or in early fall. Do you have a clarification on the date?

Director Hamos wasn't sure which project she was referring to and reviewed the current care coordination projects:

- Integrated Care program for 40,000 senior adults and people with disabilities in suburban Cook and collar counties. Phase 2 will add long term care to the service package. This is important to implement as HFS is also implementing related changes under the class action Colbert lawsuit settlement. This encompasses persons of all disability types residing in nursing homes in Cook County and their desire to transition to a community setting. The MCOs in this program will do that review in the suburbs.
- The Dual-eligible care integration Financial Model Project for seniors and disabled covered under both Medicaid and Medicare.
- The Innovations Project providing organized care networks
- Care coordination for the rest of the state.
- Solicitation within the next couple of month to serve children with complex health needs

VIII. Next Meeting

The next meeting is tentatively scheduled for September 11, 2012 at 10 a.m.

IX. Adjournment

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

Healthcare and Family Services
Bureau of Rate Development and Analysis
Outpatient Emergency Room Usage
By Month, Pre- and Post- SMART Act Changes

ER Visits

Month	3A - Emergency Level 1 Visits	3B - Emergency Level 2 Visits	3C - Non-Emergency Visits	ER Visits - higher APL	Total ER Visits
2012-04	37,766	68,283	8,772	35,461	150,282
2012-05	37,598	69,633	9,074	36,716	153,021
2012-06	34,109	61,839	8,024	33,666	137,638
2012-07	32,532	59,461	7,476	31,003	130,472
2012-08	18,747	35,517	4,336	13,457	72,057

Users of ER Services

Month	3A - Emergency Level 1 Users	3B - Emergency Level 2 Users	3C - Non-Emergency Users	ER Users - higher APL	Unique Users
2012-04	33,677	63,048	8,407	35,461	127,751
2012-05	33,474	64,163	8,689	36,716	129,831
2012-06	30,238	56,842	7,698	33,666	116,558
2012-07	28,743	54,514	7,188	31,003	110,110
2012-08	17,174	33,307	4,208	13,457	63,876

includes paid and pending claims received through August 31, 2012

Month	3A - Emergency Level 1 Visits per User	3B - Emergency Level 2 Visits per User	3C - Non-Emergency Visits per User	Visits per ER User - higher APL	Visits per Unique User
2012-04	1.1	1.1	1.0	1.0	1.2
2012-05	1.1	1.1	1.0	1.0	1.2
2012-06	1.1	1.1	1.0	1.0	1.2
2012-07	1.1	1.1	1.0	1.0	1.2
2012-08	1.1	1.1	1.0	1.0	1.1

Biography for Dr. Margaret Kirkegaard

Dr. Margaret Kirkegaard is the Medical Director of Illinois Health Connect, a Primary Care Case Management Program of the Illinois Department of Healthcare and Family Services (HFS). Administered by Automated Health Systems, Illinois Health Connect provides a medical home for nearly 1.9 million Medicaid enrollees and was awarded the Provider of the Year Award in 2010 from the Campaign for Better Health Care for improving care for Illinois Medicaid participants. As Medical Director, Dr. Kirkegaard is responsible for the design and implementation of the program, network development, clinical quality improvement and serves as a liaison to numerous community-based organizations and professional societies.

Dr. Kirkegaard is a board certified family physician and currently teaches at the Hinsdale Family Medicine Residency Program.

Dr. Kirkegaard graduated with a MPH in Health Policy from Benedictine University in 2002. In 2011, she received the Provider Advocacy Award, for advocacy on behalf of Illinois' families and children, by the Illinois Maternal Child Health Coalition.

Cheryl Lulias – Biography

Cheryl Lulias has more than 20 years of experience working with complex health care systems and a health plan in a broad range of areas including managed care operations, network management and business development. As the President and Executive Director of the Medical Home Network, Lulias leads a Medicaid pilot with public/private entities who are partnering to restructure the way healthcare is delivered and financed, leveraging the use of innovative of technology. The primary goal of the initiative is to improve the health of its target population and, ultimately to create a delivery framework to meet the needs of all vulnerable groups.

Lulias received her bachelor's degree from the University of Michigan and her Master of Public Administration from the University of Illinois.

Robert Mendonsa
Chief Executive Officer
Aetna Better Health® of Illinois

As chief executive officer of Aetna Better Health of Illinois, Robert Mendonsa's primary responsibilities include the implementation and execution of the state of Illinois' Medicaid Integrated Care Program.

Mr. Mendonsa has had a long career with Aetna. He began as a sales manager in 1991 and, since then, has held six positions in three states. Prior to his current role, he was president of small and middle markets for the 16-state North Central Region. Based in Chicago, he was responsible for profit and loss for health insurance products sold to employers with 2 to 3,000 workers.

Before re-joining Aetna, Mr. Mendonsa was the chief financial and administrative officer at Association House of Chicago, a 110-year-old social service institution dedicated to improving the lives of the neediest.

Throughout his career, Mr. Mendonsa has devoted a significant amount of time to public service causes. He has served as chair of the American Heart Association, Community Health, a free clinic on Chicago's west side, and the Aetna Foundation Regional Grants Council.

Mr. Mendonsa earned a master's degree in business from the University of Southern California and a bachelor's degree in economics from the University of California, Los Angeles. Robert is a certified public accountant.