PCCM/DM Provider Network Subcommittee
April 26, 2007
Meeting Minutes

Attendees:

Phaona Gray-Rodriguez	AHS
Joe Cini	AHS, Corporate Office
Margaret Kirkegaard, MD	AHS
Fred Hanks	AHS
Helen Baldoni	AHS
Rodney Walker	AHS
Brant Pearson	AHS
Steve Saunders, MD	HFS
Michelle Maher	HFS
Jim Parker	HFS
Brad Kupferberg	Children's Memorial Hospital, Chicago
Kelly Carter	IPHCA
Claudia Burchinal	Erie Family Health Center
Diane Pelli	Lake County Health Department
Patrick Gallagher	Illinois State Medical Society
Jasim Din	Prime Care
Kate McGovern	Loyola University
Sue Wicki	Loyola University
Tina Reagan	Loyola University
Jan Baldwin	University of Illinois
Cynthia Daniels	UIC
Kay Soto	UIC
Joe Weimholt	Illinois Maternal Child Health Coalition
Kenzy Vandebroek	Chicago Department of Public Health
Rick Leary, MD	Your Healthcare Plus
Omar Sawlani, MD	Christ Children's Hospital
Theodore Polizos, DPM	Illinois Podiatric Medical Society

Brief overview of provider recruitment

Dr. Kirkegaard chaired the meeting. The following statistics were provided on the agenda and reviewed during the meeting. The Subcommittee was reminded that each FQHC or RHC, regardless of the number of clinicians, is counted as one PCP on this table.

Progress Enrolling Doctors & Clients by Region 4-19-07

Region	Clients/Recipient Count	PCP Count	PCP Panel Slots Capacity
Cook	837,018	1,812	2,426,641
Collar	263,784	835	596,818

Northwest	182,271	421	326,335
Central	168,256	90	216,516
Southern	169,058	87	347,033
IA	0	12	23,830
IN	0	12	13,500
MO	0	3	13,275
Total	**1,620,387**	**3,272**	**3,963,948**

Dr. Sawlani inquired about the status of specialist recruitment. Dr. Kirkegaard explained that specialist recruitment was ongoing but that building the PCP network had been the primary focus of recruitment during this initial phase.

Dr. Polizos asked if DPM could be regarding as referral specialists. Dr. Kirkegaard responded yes and offered to collaborate with Dr. Polizos on this at a later date.

Update on zip code restriction policy

Jim Parker from HFS began this discussion by providing an overview of HFS' concerns about this policy. He noted that a few providers such as certain FQHCs or grant based clinics needed to adhere to zip code restrictions to meet their charters. He indicated that the initial PCP application allowed PCPs to designate zip code restrictions to prevent patients from certain zip codes to select that PCP as a medical home but most providers had interpreted the zip code question on the original PCP application as a way to designate the primary service area of the clinical and not as a means to restrict access. This confusion had resulted in some patients not being able to select their existing provider as a medical home. Mr. Parker also noted that some discussions with providers about the zip code restrictions had raised "some concern" about whether this policy violated the federal anti-discrimination laws. Mr. Parker did note that ICAAP had submitted a written response to this question in lieu of attendance at the PN Subcommittee meeting expressing concern that practices might be "flooded" with patients from distant geographic regions. Fred Hanks from AHS noted that the auto-assignment algorithm would not allow this to occur and that patients would be assigned to the closest provider if they did not have an existing relationship with a provider. Mr. Hanks also noted that the patient panel limit was absolute so no practice would receive greater than the number of patients desired. Jasim Din and Claudia Burchinal both noted that the zip code designation on their FQHC application was not intended to be a restriction at all. Dr. Sawlani agreed that all zip code restrictions should be removed. Jasim Din inquired if current zip code restrictions could be determined by accessing the IHC website. Previously zip code restrictions were listed on the IHC Provider Location of Service webpage but the zip code restrictions are no longer visible there. Any provider who does not know whether or not zip code restrictions are in place should contact the Provider Relations Helpdesk. Jim Parker then summarized that zip code restrictions would be removed from all current applications except where they are mandated for grant or other funding restrictions and providers with existing zip code restrictions would be notified of this policy change by AHS.

Security measures for claims data

Dr. Kirkegaard introduced this topic by explaining that HFS/AHS planned to make 2 years of claims data available to clinicians in order to assist with clinical care. However, HFS/AHS were trying to establish the correct balance between accessibility (and therefore usefulness of data) and security. Kelly Carter asked if there was any differentiation between certain classes of data such as family planning, behavioral health and HIV status. Dr. Kirkegaard responded that AHS had investigated whether or not behavioral health diagnoses had special HIPAA protections but the amount of info available on claims data, which does not contain any actual medical notes, did not meet the HIPAA definitions for special protections. AHS agreed to look into what HIPAA policies would apply to family planning and HIV status.

Jim Parker explained that the current MEDI system has a process for digital certification that can identify each person who logs into the system. The provider can then also designate certain staff members who can access the MEDI system. Dr. Sawlani agreed that a unique user name and password for each user seemed appropriate. Brad Kupferberg indicated that the info systems at Children's required each user to have a unique user name and password. Sue Wicki from Loyola explained that they use the electronic medical record system EPIC and that each user has a security level assigned via job type that allows differential access to the system. The system also creates an audit trail that is periodically reviewed for inappropriate access. Jan Baldwin from UIC stated that she was concerned about the proposed access to claims data without tighter security measures. Kelly Carter was asked if many FQHCs had an EMR and whether these systems had unique user names for every person or shared user names within an FQHC. She reported that she believed that a few of the FQHCs had electronic records and that they had unique user names and passwords. Ms. Carter also inquired if AHS/HFS intended for the PCP to have access to the claims data of his/her own enrollees or if there would be unlimited access. Dr. Kirkegaard responded that the plan was to give all providers access to all claims data so that providers caring for patients in the ED or in another clinical setting where the historical data might be lacking could use the claims data to better manage the patient's care. Jan Baldwin indicated that UIC had to restrict access to their system for their community partners to the records of just those patients linked to the community partner. Fred Hanks commented that the proposed broader access to claims data was to assist specialists with patient care and there would be no way of linking most new patients to a specialist. Dr. Polizos suggested that since each PCP was required to register a referral for specialty care, the referral could 'unlock' access to the claims data. Dr. Kirkegaard asked if having unique user names and passwords would be unduly burdensome for FQHCs with a large number of staff. Kelly Carter responded that she thought that would not be overly burdensome and most FQHCs were already used to that type of access system for MEDI. Jasim Din also noted that each FQHC would have a security officer to manage data issues for HIPAA compliance. Michelle Maher noted that any system devised by AHS/HFS would be vetted by legal counsel at HFS and would be HIPAA compliant. Jim Parker concluded that AHS/HFS would

explore other security systems and defer making claims data available until adequate security was in place.

Availability of PCP directories

Dr. Kirkegaard introduced this topic by noting that several patient advocacy groups and entities such as the health departments had requested access to the lists of available PCPs. AHS' current policy was not to make the directory publicly available due to privacy concerns for the participating physicians. Dr. Sawlani noted that private insurance companies published directories of participating physicians. Kelly Carter suggested that there could be a directory of PCPs that would be available to the advocacy organizations but not to the public. The possibility of asking the PCPs for permission to include their names in a directory was discussed. Joe Weimholt also noted that a directory would be helpful in assisting patient advocacy groups with "connecting" patients with health care. Dr. Kirkegaard pointed out that that was precisely the function of AHS in the Illinois Health Connect program. Michelle Maher also noted that any public list would not have the complete information about each PCP that a patient could obtain by working through the Client Services Representatives at AHS. Patrick Gallagher noted that a partial list of PCPs who agreed to be listed might actually be misleading since PCPs might be willing to accept new patients but not want their names on a public list. Kelly Carter asked if AHS was prepared to work with non-Illinois Health Connect HFS clients to assist them with finding medical care. Dr. Kirkegaard responded that AHS would also help those patients find a PCP and access specialty care. Fred Hanks noted that, in his 20 years of experience with working with Medicaid providers in other states, public lists had negative repercussions on the long-term viability of the provider network. Kelly Carter asked about the listings of PCPs on the current web-based PCP search. She noted that during a search for a PCP on the web site,100 PCP names would be returned but that they were listed alphabetically. Fred Hanks clarified that in the general provider search, the search results are listed in alphabetical order based on the information entered. However, on the provider search in the enrollment function, the results are returned based on the distance from the address of the client performing the search. Ms. Carter also asked what criteria were used to select the ten PCPs that would be included in a paper directory sent to clients who requested one. Dr. Kirkegaard stated that they would be filtered based on the request of the patients by criteria such as age of patient, gender of physician and specialty and that after those criteria were met, a listing of the ten closest PCPs who met the criteria would be mailed to the client. Dr. Kirkegaard also noted that the clients could request a listing of additional PCPs if none of the PCPs on the first list were appropriate.

Other business

Jasim Din asked if there was any way to obtain a "master" panel roster for all providers at a site. Fred Hanks responded that AHS had created the panel rosters in both PDF and CSV (similar to Excel) formats. Kelly Carter asked how this could be accessed. Mr. Hanks responded that the CSV formats were not completely finalized but would be available soon. A notice will be sent to providers when they are available. Dr. Sawlani asked if any provider in a group could see a patient and submit a claim. Dr. Kirkegaard

explained that “affiliations” could be made to providers both inside and outside the group and the claim would not be rejected.

Addendum

The PN Subcommittee meeting originally scheduled for May 16th has been postponed until Thursday, June 21 from 11:00 to 12:15 CST. The conference access number is 1-877-900-4832. The conference number is 7101 and the code is 3120#.