Illinois Department of Healthcare and Family Services
PCCM Provider Network Subcommittee
Meeting Minutes for Sept 22, 2011

Attendees:

Margaret Kirkegaard, MD	AHS
Cari VonderHaar, RN	AHS
Vicky Hosey	HFS
Kathy Moles	HFS
Sharon Pittman	HFS
Michelle Maher	HFS
Pam Bunch	HFS
Jodie Edmonds	HFS
Jim Parker	HFS
Claudia Burchinal	Erie Family
Marie Lindsey	ISAPN
Wayne Franklin, MD	HFS
Vince Keenan	IAFP
Brad Kupferberg	Children's Memorial Hospital
Jill Sproat	DHS, School-based clinics
Adali Vilchis	Lake County HD
Julie Garcia	VNA
Omar Sawlani, MD	Christ/Hope Children's Hospital
Mike Temporal, MD	SIHF
Darin Jordan, MD	CDH
Scott Allen	ICAAP

Dr. Kirkegaard chaired the meeting. Introductions and roll call were performed.
Wayne Franklin, MD, noted that he had attended the last Provider Network Subcommittee meeting on 6-9-11 but his name was not noted in the minutes. Dr. Kirkegaard apologized for the oversight.

Payment Cycle:

Jim Parker from HFS talked about the payment cycle issues. He noted that the Provider Release from July 28, 2011 was an attempt to give providers additional information but it created several more questions. He stated that HFS was considering an additional Provider Release to clarify the first Release. He noted that the budget was deliberately left underfunded. HFS cannot decrease eligibility due to the federal maintenance of effort rules and that HFS did not want to cut provider rates. Thus, the payment cycle would have to be extended. Mr. Parker noted that the department paid all the Medicaid bills it had on hand and providers were actually paid very rapidly through the end of June to maximize the federal match and that had contributed to the perception of slower payments now in August and September. He went on to explain that the comptroller had allotted $100 million per month for payments in July and August. In September, that amount increased to $300 million. While this allows for more timely payments, it is still not adequate to meet all of the Medicaid provider claims. Mr. Parker noted that moving forward, he anticipated that most expedited practitioners (practitioner refers to providers such as podiatrists, APNs and physicians) would be paid on the 30 day cycle or "very close to

30 days" and that payment would be made weekly. Non-expedited practitioners should be paid within 30-60 days and that HFS was working to ensure that FQHCs would also get paid in 60 days. Other providers such as hospital and transportation vendors may see the payment cycle stretch to 120-160 days. Mr. Parker stated that he anticipated that the payment cycle would improve after December when the other unpaid bills had been satisfied by the comptroller's office. Adali Vilchis asked if there was any impact on the length of time allowed for claims submission. Mr. Parker responded that providers have one year to file claims. Dr. Franklin asked for clarification about hospital payments. Mr. Parker stated that hospitals were "severely under appropriated" and by the end of the year payments could be extended to 160 days. He added that some hospitals fell into expedited categories and would see payments in 15-30 days depending on their status. Dr. Kirkegaard asked if the IHC care management fees would be paid on the expedited cycle and Mr. Parker said that he would check on this.

Care Coordination Innovation Projects:

Jim Parker from HFS reviewed the Care Coordination document that had been distributed to the subcommittee members. He noted that the language of the reform legislation passed in January of 2011 required 50% of all HFS patients to be enrolled in care coordination systems by 2015. While MCOs are regarded as currently meeting the care coordination requirements, he noted the legislative language allowed the care coordination definition to be expanded to include innovative provider organizations. He stated that HFS would create a solicitation for Care Coordination entities by the end of 2011. This would not be a formal procurement process so there will be more latitude in creating the care coordination entities, developing the proposals and in the selection process. He indicated that HFS was deliberately trying to allow for creativity and innovation and was not going to be too prescriptive in the solicitation process. He added that there was a meeting scheduled for Oct 13 in Chicago which would also be available via webinar that would further define the quality measures, target populations and outcome measures for the Care Coordination Entities.

Mr. Parker explained that HFS was working with several charitable foundations to develop a "Data Mart" so that providers could query HFS claims data in a uniform way to assist with development of proposals. The plan includes hiring an IT contractor to create the Data Mart. For example, if an organization wanted to target the AABD population, they could query the Data Mart for specific information on costs and populations in various counties. He noted that the number of successful proposals would be limited to 5 or 6 but not capped at a specific number. Mr. Parker went on to explain that HFS intends to try to link the program into the federal program on Health Care Homes which would allow for a 90% match on funds. This means that any Care Coordination Proposal must target complex patients such as patients with multiple chronic diseases or mental illness. He noted that the financial plans included in the proposals could be flexible and could range from shared savings options to a per member per month payment. HFS expects the Care Coordination Entities to eventually be able to assume risk for their populations but that would not be an initial requirement. Dr. Sawalni queried that this was structured similarly to a Provider-Hospital Organization (PHO). Mr. Parker responded that was correct. HFS wanted to include provider types including primary care, specialty care, behavioral health and hospitals. Dr. Sawlani asked if HFS would still be the claims processing agent and Mr. Parker confirmed that was true. He stated that the goals of the program were connecting patients to care, promoting wellness and addressing care transitions and not claims processing. Dr. Sawlani asked if this would be considered a Medicaid Accountable Care Organization (ACO). Mr. Parker stated that it would be similar in care arrangements but not financial arrangements. Dr. Sawlani asked what would attract hospitals to increase savings since they would likely get paid less. Mr. Parker responded that hospitals would be

motivated by reducing ED use since they were underpaid for ED services. Mr. Parker also noted that all the details had not been finalized for how these entities would function and that HFS was hoping that providers would propose innovative, local solutions. Mr. Parker noted that these entities would layer on top of Illinois Health Connect and some sort of model would have to be formulated to define attribution of patients or lock them into one Care Coordination Entity so shared savings could be calculated.

Illinois Health Connect Client Video:

Dr. Kirkegaard announced that IHC had created an educational video for clients focusing on the medical home model and services available through IHC. She noted that the video was available in both English and Spanish. It was posted on the IHC website and DVD copies are available for free. Dr. Franklin suggested partnering with the PTAs in Chicago Public Schools and Dr. Sawlani asked if this could be considered marketing. Dr. Kirkegaard explained that the video does explain IHC-specifics services but the intent of the video was education about the medical home and not marketing.

IHC Annual Provider Satisfaction Survey Results:

Subcommittee members had a chance to review the Annual PCP Survey results. Dr. Kirkegaard pointed out that the 93% of respondents said that IHC was beneficial for patients and nearly 90% were satisfied with the administration of the IHC program. She thanked individual providers and provider groups for assisting with survey completion. Scott Allen from ICAAP asked if the survey would be posted on the IHC website as in previous years. Michelle Maher stated that HFS needed to give final approval and then it could be posted. Mr. Allen said that this would be good so that the PCPs who completed the survey could review the results and note that changes were being made based on feedback thus reinforcing the value of participating in the annual survey and providing feedback to IHC in general. Dr. Temporal asked about the survey questions showing that nearly 50% of PCP respondents expressed difficulty in accessing specialty care. Dr. Kirkegaard outlined the assistance that IHC can provide for accessing specialty care for patients and that between 60-65% of patients who had used these services had access to specialty care. Dr. Kirkegaard asked Michelle Maher from HFS to explain if HFS was making any policy changes to encourage more specialist participation. Ms. Maher responded that the Care Coordination projects were intended to help with access to specialty care. Dr. Franklin asked if there were any differences between access to care in Chicago vs. downstate. Dr. Kirkegaard responded that no geographic subgroup analysis had been performed but anecdotally, the issue was state-wide. Dr. Franklin noted that this survey was the report of PCP perception and that measuring the impact on actual care would be much harder. Dr. Kirkegaard suggested that some questions could be incorporated into the Annual Client Survey but that would be confounded by the patients' perception of the necessity of specialty care. Dr. Sawlani noted that some specialties were easier to access than others. Dr. Kirkegaard agreed and noted that mental health, orthopedics, ENT, and neurology were consistently viewed as most difficult to access.

Breast Cancer Awareness Activities:

Dr. Kirkegaard noted that October was Breast Cancer Awareness month. She noted that HFS was sending an informational insert about mammography to women with the monthly medical card. She added that IHC had blast faxed information to providers and that biannual mammography was an IHC bonus measure and noted on the panel rosters. She added that recently IHC was trying to expand the

clinical reminder functions of the call center and had partnered with Chicago Department of Public Health and REA Clinics downstate to identify and outreach to women due for mammography.

Update on Claims History:

Dr. Kirkegaard informed the group that mental health conditions were now included in the IHC Claims History. Previously, due to state law, IHC Claims History excluded claims for mental health diagnoses and prescriptions. Dr. Temporal asked if pain medications were included and Dr. Kirkegaard said yes if the claim was submitted to HFS however, she also noted that the Illinois Prescription Monitoring Program included all scheduled prescriptions filled by any pharmacy for all patients regardless of payer status and that may be a better way to track potential misuse of narcotic medications.

Dr. Kirkegaard asked if there were any other items for discussion. She thanked the group for their input and noted that the next meeting was scheduled for December 1, 2011 and that an agenda would be forthcoming.