Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
March 18, 2011
401 S. Clinton Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Members Present
Eli Pick, Chairman
Susan Hayes Gordon, CMH
Kathy Chan, IMCHC
John Shlofrock, Barton Mgt.
Mary Driscoll, DPH
Judy King
Linda Diamond-Shapiro, ACHN
Andrea Kovach, Shriver Center
Edward Pont, ICAAP
Karen Moredock, DCFS
Melissa Vargas, AAPD Head Start DHI
Renee Poole, IAFP

Members Absent
Alice Foss, IL Rural Health Assn.
Sue Vega, Alivio Medical Center
Glendean Sisk, DHS
Jan Costello, IL Home Care & Hospice Council

HFS Staff
Julie Hamos
Theresa Eagleson
James Parker
Kelly Cunningham
Robyn Nardone
James Monk
Ann Lattig

Interested Parties
Cassie Ayres, IARF
Mary Ellen Baker, Medimmune
Kathy Bovid, Bristol Myers, Squibb
John Bullard, Amgen
Mary Capetillo, Lilly
Geri Clark, DSCC
Kathy Garvin, Taro Pharm.
Elena Grinko, Quest Diagnostics
Shellie Harden, DHS
Barbara Hay, FHN
Marvin Hazelwood, Consultant
George Hovanec, Consultant
Glen Johnston, GSK
Michael Lafond, Abbott
Diane Martinez, Alivio Medical
Mike McCabe, UHC
John Nicolay, Maximus
Jim O'Leary, APS
Mary Reis, DCFS
Doug Schenkelberg, Heartland Alliance
Maria Shabanova, Maximus
Nelson Soltman, Legal Assistance Foundation
Jo Ann Spoor, IHA
Chester Stroyny, APS Healthcare
Keri Toback, CMS
Mandy Ungrittanon, Quest Diagnostics
Martha Wright, Comprehensive Bleeding Disorders
Mark Werner, Ill Adoption Advisory Council
Matt Werner, Consultant

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I. Call to Order

Chairman Pick called the meeting to order at 10:03 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Review of the Minutes

Judy King recommended a change to the minutes. With this change, the January 2011 minutes were approved.

IV. Director's Report

HFS director, Julie Hamos, provided the report.

Fiscal Year 2012 budget: In January, the department had made cost saving recommendations as part of the Medicaid reform legislation. On March 17th, state senate republicans proposed more than $6 billion in budget adjustments for next fiscal year. They have suggested that the department should be able to cut the budget by 12.5 percent and reduce the Medicaid budget by 50 percent. The legislature has now asked for an additional $550 million in cuts.

There are three major areas from which cost savings can be achieved: 1) optional populations covered; 2) optional services covered and; 3) payment rates. Meeting participants were provided a handout showing "Optional populations' current enrollment and liability & Optional services for mandatory adult populations" (Attachment 1-Corrected version as of April-2011). This handout was referenced as potential cost savings strategies were discussed.

1) Optional populations: The expanded All Kids population was already capped at 300% of the FPL under Medicaid reform (effective July 1, 2011). In addition, the state funded Illinois Cares Rx (ICRx) program was proposed to be eliminated as part of the of the fiscal year 2012 budget. The ICRx program provides assistance to low income seniors and disabled persons with costs under the Medicare Part D prescription drug program. The department is looking at ways that some participants may still be covered, including premium or copayment costs increasing and lowering the income standard from the current 250% of the FPL to 200% or 133% of the FPL.

2) Optional services: Optional medical services include things like pharmacy, supportive living facilities, home and community based waivers and dental services. If the department reduced these services, the savings would amount to only $670 million over 5 years. As of yet, there are no service cuts.

3) Payment rates: The Governor's proposed budget calls for a 6% rate reduction for most providers, including nursing homes and hospitals.

There was group discussion on what members could do to support the department; what potential cost savings might be made; and whether the suggested amount to be cut was overestimated. Judy King asked that the department provide a budget that showed how it arrived at various (cost saving) projections.

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Principles of Care Coordination

Director Hamos opened up the discussion on care coordination by stating that the Medicaid reform legislation requires the department to enroll at least 50 percent of Medical Assistance program enrollees in "coordinated care" by January 1, 2015. To achieve this, the department will be looking at new service delivery models, as well as the traditional managed care model. She noted that coordinated care is a centerpiece of the *Patient Protection and Affordable Care Act* and it allows for a service delivery package under which all care is organized around the needs of enrollees. The department has had individuals from hospitals, social service agencies and FQHCs share their experiences with different service delivery models. For example, some hospitals are looking at accountable care organizations. The move to coordinated care is also being seen in the private sector.

What many other states have done is assign clients to managed care organizations (MCOs). This has been the choice because the MCO model has been tested. Our approach will be more innovative, in that we will look for service delivery models that incentivize providers to achieve better health outcomes for their patients. Other than voluntary managed care, the department's only coordinated care program is the new Integrated Care Program. The two companies selected to administer the program have national experience, but are new in Illinois. They must depend on existing clinics, hospitals and other providers as they develop their networks necessary to provide integration of care.

Director Hamos provided a handout, *Principles of Care Coordination, First Draft, 3/18/11* (Attachment 2). The handout reflects changes required under the Medicaid reform law and also research done on coordinated care. The handout was used as a reference for group discussion. Some discussion points follow.

- The department should look to the state of New York as most Medicaid enrollees are in managed care.
- The concept of coordinated care is not new. We need to look at how continuity of care is impacted. The plan of care should tie services to health indicators. The example of Chicago Public Schools working with the Illinois College of Optometry was mentioned.
- There is concern about working with the MCO model. A meeting participant described how it took 2 hours coordinating between an MCO and the care provider for a level 2 ultrasound. There is a need to invert the pyramid and think from the patient and smaller providers' perspective working with coordinated care.
- The medical home concept should be used in developing the coordinated care model. An understanding of how coordinated care will intersect with the medical home concept is needed.
- Look at the definition of medical home as a planned approach to care and flush out where care takes place. For example, a flu shot may be provided at Walgreens or CVS. The location for service is secondary to the patient getting the flu shot. A principle of access to care should be to get the right care at the right place at the right time.
- Oral health should be considered as a primary health service in coordinated care. The department should list prevention and wellness as part of the coordinated care principles.
- There should be a meaningful use of electronic health records as the repository of the patient care plan. The electronic medical record should facilitate two-way communication. There needs to be a dialogue between the patient and practitioner done by the integrator or care coordination agency.

- CMS is working informally at the central office in developing a health home model. There are 12 members, with 3 of the 12 being from the Chicago office. It was suggested that a CMS staff person be invited to the PCCM subcommittee.

Director Hamos shared that building a care network is a challenge. It can be difficult to get providers to join. The department would like to see a "grassroots-up" development. But, when engaging stakeholders and planning workgroups there is also the challenge of knowing who to invite given the State's procurement requirements. The department will hold stakeholder meetings, somewhat like the meetings that are beginning on hospital payment reform. The first hospital payment reform stakeholder meeting will be on March 28th, with the second meeting to occur in April.

George Hovanec asked about the relationship of the unified budget and rebalancing called for in Medicaid reform and the Governor's budget and care coordination and whether or not these will come together or be on separate tracks.

Director Hamos stated that we would eventually like to see these integrated. Patients have multiple care needs and the department wants to develop a continuum of care.

It was asked who in the Medicaid population would be part of the coordinated care system.

Director Hamos stated the legislation calls for selecting from all populations. Some advocates felt the focus has been unfairly directed toward the disability groups. One must keep in mind that the department has overlapping populations with new persons being added in 2014 with income at or below 133% of the FPL. This will include single males with chronic conditions needing care coordination.

Chairman Pick summarized that the department doesn't have the answers as yet on how the mechanics of coordination of care will work but is focused on incorporating different models. It is an evolving process.

V. Update on Integrated Care Program

James Parker, Deputy Administrator for Operations, provided the report. The mailing of enrollment packets began on March 14th. The first enrollment effective date will be May 1st.

The first packets went to Northern Cook County and will follow zip codes in numeric order going from North to West to South Cook County. Mailings will then be done for the collar counties. Approximately 2,500 letters are being mailed each week. It will take about 4 months to send 40,000 enrollment letters. The department and vendors continue to work in the collar counties to improve the provider networks. The next Integrated Care Program stakeholder meeting is April 7th.

Mr. Parker advised that the enrollment packet may be viewed online at the Client Enrollment Broker Web site. The department will send the link to committee members - http://www.illinoiscebicp.com/ He reviewed the enrollment process stating that if no choice is made 30 days after the first packet was mailed, a second packet is sent to the person. The second packet tells the person if they don't make a choice within the next 30 days, they will be assigned to a default enrollment site. Mr. Parker added that all assignments are prospective and the first auto assignment would not happen until July 1st.

There is a review process to examine the care experience in Cook and the collar counties. It is structured with pay for performance. Mr. Parker advised the committee that the University of Illinois

- Chicago has a separate evaluation team looking at outcomes, access to service and customer satisfaction.

Regarding continuity of care, Mr. Parker stated that under the HMO Patient Protection Act, the HMO must pay the existing PCP for the first 90 days of enrollment. For pregnant women, the HMO is required to pay for services through birth at the HMO rate. PCP authorization is not required for specialty care or mental health services. He added that it is the HMO's job to engage enrollees and providers. Enrollees are asked to complete a questionnaire with questions about specialty care needs. Director Hamos added that a program goal is to get every PCP enrolled in the network.

Director Hamos stated that the department is moving ahead on the Health Benefits Exchange. The department had issued an RPF that included the Eligibility, Verification and Enrollment (EVE) component and the vendor(s) will be announced soon. It was suggested that the vendor(s) meet with the MAC.

Dr. Pont made a motion that a MAC subcommittee be formed to examine how the current PCCM system may be allowed to be a coordinated care option. The motion was then opened for discussion.

Mr. Parker asked if the plan was to combine DM and PCCM. Dr. Pont envisioned any change as open to discussion. He noted that PCCM has been a successful case management model so far and it would make sense to help it evolve to meet the coordinated care criteria. Mr. Parker added that there is currently a PCCM/DM steering committee. Chairman Pick suggested that a workgroup would look at the existing PCCM activity to help establish a charge for a new subcommittee. He suggested that the subcommittee would be open to MAC members and participants at the MAC meeting.

The motion was voted on. All with one abstention voted in favor of establishing a new subcommittee to evaluate the PCCM program in relation to the department's care coordination initiative.

VI. Additional Meeting Dates May 6th or August 5th

At the committee's request, the department proposed an additional meeting date of either May 6th or August 5th. Ms. King requested bi-monthly meetings. The committee chose May 6, 2011 as the additional meeting date.

VII. Subcommittees Reports

Public Education Subcommittee Report: Kathy Chan provided the report. The last meeting was in January. There were several topics discussed that included the Integrated Care program; an update on moving to a durable medical card; and discussion on a client portal that could communicate information to clients and get information from them. The next meeting will be held in April.

Long Term Care Subcommittee report: Kelly Cunningham reported that the subcommittee met on March 11, 2011. The topic areas included:

- Coordinated care and the Integrated Care Program;
- Proposed budget for FY2012 and the impact on providers;
- Delivery of a PowerPoint presentation on a history of seminal events in Long Term Care and how these are a catalyst for LTC rebalancing;
- Update on Money Follows the Person.
- New opportunities in the Affordable Care Act and some options for new directions.

The LTC Subcommittee's next meeting is in June.

VIII. New Business/Announcements

- Mark Werner with the Illinois Adoption Advisory Council, asked for MAC and HFS' assistance regarding a policy issue. Adoptive or guardianship children, some with chronic health conditions, age out and loose their coverage through HFS, but are still are in need of medical care. Mr. Werner proposed that since children under ACA can now be covered by commercial insurance through age 26, they would like to see this same policy apply to DCFS adoptive or guardianship children.

  Director Hamos advised that this aging out is also true for All Kids children. We are looking at a gap in services until 2014 when there would be coverage under ACA.

  Chairman Pick suggested that Mr. Werner submit a proposal for department staff to review.

- A first floor training room at 401 S Clinton is being redesigned to accommodate about 80 persons for larger meetings.

- The department is redesigning the HFS website.

IX. Adjournment

The meeting was adjourned at 11:58 a.m. The next MAC meeting is scheduled for May 6, 2011.

Optional populations current enrollment and liability
& Optional services for mandatory adult populations
Liability recognized in SFY 2010
HFS GRF and related funding only

Revised Copy as of April-2011

Attachment 1
MAC Meeting Minutes
March 18, 2011

Claims Based

Population Group	As of	Recipient Count	Notes / Comments	Liability ($1,000)
Optional Populations		**505,801**		**$ 739,057**
Family Care SS - 49 % FPL	1/1/2011	46,083	**ACA MOE prohibits reductions**	$ 112,247
Family Care 49 -90% FPL	1/1/2011	57,960	**ACA MOE prohibits reductions**	$ 146,868
Family Care 90 - 133% FPL	1/1/2011	83,227	**ACA MOE prohibits reductions**	$ 177,360
Family Care 133 - 185% FPL	1/1/2011	23,469	Requires Hardship waiver of ACA MOE request	$ 42,075
Family Care 133 - 185% FPL - Rebates Only (Non Match)	1/1/2011	1,421	Optional coverage methodology, which subsidizes private insurance premiums. If hardship waiver granted, this population would be combined with group above. Liability reflects cost of premium subsidies, not service purchase costs. (This population is non match currently)	$ 5,372
Family Care > 185% FPL	1/1/2011	1,751	This population is no longer allowed to grow. (per P.A.96-1501) and will eventually phase out.	$ 4,660
Torture Victims and Asylees	1/1/2011	74	Non Match Population	$ 259
General Assistance Adults	1/1/2011	9,171	Non Match Population	$ 16,384
Illinois Cares Rx Population	1/1/2011	178,598	Governors introduced budget proposes elimination of this program, SFY 2012 Non match program	$ 114,164
All Kids above 300% FPL, not eligible for Federal Matching funds	1/1/2011	4,734	Non Match Population. Further expansion prohibited by law.(per P.A.96-1501) and will eventually phase out	$ 5,806
All Kids below 300% FPL, not eligible for Federal Matching funds	1/1/2011	66,782	Non Match Population. Further expansion prohibited by law.(per P.A.96-1501) and will eventually phase out	$ 65,914
All Kids between 200 - 300% FPL, Part of a pending title 21 State Plan Amendment	1/1/2011	31,077	All Kids population part of pending Title 21 SPA (65% FFP when approved) (Federal revenue from approval of this SPA is assumed in the Gov. budget)	$ 30,098
State Renal Program	1/1/2011	200	Non Match Population	$ 711
State Sponsored Hemophilia Program	FY-2012 Est.	240	Non Match Population	$ 15,035
State Sponsored Sexual Assault Program	FY-2012 Est.	1,014	Non Match Population	$ 2,104
Total - Populations not subject to MOE	**1/1/2011**	**318,531**		**$ 302,581**

Adult Optional Services (Incl. Seniors)

Optional Service	Notes / Comments	$	1,419,145
Pharmacy Services (Drug and OTC)	Reductions in Rx spending will also result in reduction of Rx Rebate revenue. Reduced Rx benefits also likely to result in higher acute care cost from failure to comply with Rx protocols	$	932,428
LTC - Supportive Living Facility (Waivers)	These individuals are NH eligible, and elimination of SLF option would result in higher NH expenditures	$	116,199
Home Care		$	81,615
Medical Supplies		$	80,446
Medical equipment/prosthetic devices		$	64,120
Dental Services		$	52,603
LTC - Intermediate Care		$	42,594
Optical Supplies		$	8,436
Outpatient Services (General)	OP services are optional when provided outside of the hospital. Not practical to cut, as services would shift to hospitals costing more.	$	7,018
Physician Services	Certain physician classified services, or delivery options are optional	$	6,973
Podiatric Services		$	5,649
Inpatient Hospital Services (Psychiatric)	Certain delivery locations are deemed optional for adults. Dropping service would have significant effects on thr programs of other agencies.	$	5,618
Nursing service		$	3,896
Anesthesia Services		$	3,623
Physical Therapy Services		$	2,542
Optometric Services		$	1,861
Occupational Therapy Services		$	1,044
Chiropractic Services		$	922
Mental Health Rehab Option Services	Dropping service would have significant effects on thr programs of other agencies.	$	803
Audiology Services		$	400
Speech Therapy/Pathology Services		$	206
Targeted case management service (mental health)	Dropping service would have significant effects on thr programs of other agencies.	$	148

Notes:

Liability expressed as State Fiscal Year Recognized (DCNd)

Liability is HFS GRF and related funds only, liability for these individuals and optional services exist in other agencies.

All liability should be considered matchable under the standard applicable Federal - State Match (50-50) rate unless otherwise noted as Non-Matchable

PRINCIPLES OF CARE COORDINATION

First Draft, 3/18/11

***Person-centered*.** Care coordination organizes care around the diverse needs of the Medicaid enrollee in order to promote health and independence. The care coordination team conducts an assessment, including, as appropriate, the enrollee's physical, mental, psychosocial, and cognitive functioning, medication use, and family caregiver capacity to assist with care. The assessment is conducted in accordance with the enrollee's risks, needs, goals and preferences.

Comprehensive services, linked by an integrator. A range of services is offered to meet the majority of the individual's needs, including a primary care physician, referrals from the primary care physician, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, and when appropriate, rehabilitation and long-term care services. Care is delivered in a culturally and linguistically appropriate manner, incorporating evidence-based practices as appropriate and available. Where necessary, the care coordination program assigns an integrator to the enrollee, with responsibility for providing or arranging the majority of care needed to ensure the continuity of care across multiple settings and providers.

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Assessment of quality, performance and health outcomes. Standards of quality care and outcomes are measured to assess the performance of the care coordination program. Where possible, electronic health records are used to help care coordinators collect data and manage treatments and services.

Risk-based payment systems. Payments to care coordination programs are made either on a capitated basis in which a fixed monthly per enrollee is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements. The program or program integrator may be paid for care coordination services without being responsible for direct payment for medical services provided; however, payments include a component of risk, based on overall cost of care or on quality and outcome measures. Payments to providers are

adequate to provide continued access to quality healthcare for Medicaid enrollees, with movement toward financial accountability systems where payments reflect the complexity of the enrollee's condition, the quality of care rendered and outcomes for the enrollee.

Population-based. Care coordination programs serve an identified population that is enrolled. The program or program integrator does not exclude any member of the population for which it is responsible. Enrollees may be required to enroll in a care coordination program, with enrollee protections to assure quality and access.

Reduced bureaucratic barriers. State agencies work to abide by principles of coordination, by streamlining their policies, procedures and other requirements to promote the efficient use of care coordination across programs, agencies and budgets. Providers and vendors are offered incentives to minimize administrative barriers in their organizations.