Illinois Department of Public Aid
Medicaid Advisory Committee

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

July 21, 2006

Members Present
Eli Pick, Chairman
Neil Winston, M.D.
John Schlofrock, Barton Mgt.
Robert Anselmo, R.Ph.
Robyn Gabel, IMCHC
Janette Michaels for N. Crossman, DHS
Jill Fraggos for Susan Hayes Gordon
Diane Coleman, PCIL
Mike Jones, IDPH
Ralph Schubert, DHS

Members Absent
Pedro A. Poma, M.D.
Richard Perry, D.D.S
Alvin Holley
Kim Mitroka – Christopher Rural Health
Debra Kinsey, DCFS

HFS Staff
James Parker
Theresa Eagleson Wyatt
Jacquetta Ellinger
Sinead Madigan
Stephanie Hanko
Mary Miller
Kathy Chan
Carla Lawson
James Monk

Interested Parties
Kenzy Vandebroek, CDPH
Randall Mark, CCBHS
Esther Morales, Harmony Health Plan
Peggy Powers, IADDA
Gerri Clark, DSCC
George Hovanec, Consultant
Mathew Marsigha, AHS
Joy Mahuria, Comp. Bleeding Disorder Ctr.
Mark Miller, KOS pharm.
Peter Engebretson, TCOS pharm.
Kathy Bovid, Bristol-Myers, Squibb

Medicaid Advisory Committee (MAC)
Meeting Minutes

July 21, 2006

I. Call to Order

Eli Pick called the meeting to order at 10:07 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Review of the Minutes

January, March and May minutes were reviewed. The minutes for the three meetings were approved.

IV. Administrator's Report

James Parker, Deputy Administrator for Operations, provided an update on 1) All Kids; 2) Disease Management (DM) and Primary Care Case Management (PCCM) activity.

1) All Kids

Theresa Wyatt, Deputy Administrator for Programs, stated that the application numbers are up and we are continuing to receive sign-ups. Enrollment statistics were provided to members.

Chairman Pick asked how All Kids and PCCM/DM programs interrelate.

Mr. Parker stated that tying PCCM and All Kids together has caused some confusion. A common mistake is to think that PCCM applies to kids only or to the expansion group only. He noted that the expansion group would not be able to choose an MCO.

He explained that MCO agreements expire at the end of the month. Negotiations are complete for the new plan year. Effective August 1, only Harmony and Family Health Network are participating. Amerigroup has dropped out and their enrollees will be converted to fee for service. There are an estimated 37,000 Amerigroup enrollees affected.

Chairman Pick noted that the changes are complicated, so there is an opportunity to create confusion.

Mr. Parker stated that the Outreach Unit has been going around the state to help explain the plans and programs. We get many questions and recognize the need for education. We will continue the outreach process over the next 6 months.

Ms. Fraggos stated that Children's Memorial hospital has developed a fact sheet describing the main changes. It addresses different parties affected, e.g., what do the changes mean for physicians or beneficiaries. She plans to share the fact sheets with HFS and AHS.

Mathew Marsigha stated that Automated Health Systems (AHS) would be developing educational materials and plans to work with the Educational Subcommittee of the MAC.

Jacquetta Ellinger, Deputy Administrator for Policy Coordination, stated that although not having met as of late, the MAC Public Educational Subcommittee has 10 appointed members. Kenzy Vandebroek, of the Chicago Dept. of Public Health has been the most active member. Ms. Ellinger stated that AHS should make sure they have HFS staff, Kathy Chan's contact information as she will help staff the education workgroup.

2) Disease Management (DM) and Primary Care Case Management (PCCM)
Mr. Parker stated that AHS is the PCCM vendor. AHS has started working with Rural Health Centers (RHC) around the state. The nurse consultation line is up and running. Primary Care Providers (PCPs) are being secured. Access Community Health Network and others have shown a good response. AHS is beginning to recruit PCPs generally.

The next step after meeting with the RHCs is working with FQHCs so persons can choose as their PCP. The educational materials are ready. In the next couple of weeks, everyone will receive the educational packet. The contract has incentives so that if more persons choose rather than being defaulted to a PCP, the vender will receive more money.

The PCP referral process will not be in place until a year from now when the PCP system is in place. HFS has contacted hospitals, clinics and large practitioners on how to know who to see and ability to refer to others. HFS wants to make sure we have a system that works well.

Robyn Gabel stated that school health center clinics are trying to fill out the PCP form. She asked whom to call for assistance in completing the process.

Mr. Parker identified Kelly Carter, Bureau of Contract Management Chief. He further stated that the PCP form has only gone to the FQHCs so far.

Jill Fraggos had a copy of an agreement from another meeting and asked if this is what is being sent to providers. She also asked if providers must complete an application and agreement to be a PCP.

Mr. Parker advised that the actual agreement packet includes more detail about PCP and confirmed that providers must complete the agreement to become a PCP.

Diane Coleman asked what was meant in the May minutes about the establishment of protocols and standards.

Mr. Parker advised that during the first year of the contract, the vendor is working with providers on protocols. In the second year, patient profiles will be developed. Both the DM and PCCM vendors are working with providers on protocols and standards of patient care.

Ms. Coleman asked if the Rehab Institute of Chicago (RIC) would be involved with identifying standards. She suggested calling several persons, including Dr. Kristi Kirsehner.

Mr. Parker stated that we would look at doing this.

Ms. Coleman asked what the mandatory component would encompass.

Mr. Parker stated that, beginning December 2006, persons in eligible groups would be asked to choose a PCP. He stated this included most persons with medical coverage with some exceptions such as dual eligibles, SSI recipients, DCFS children and nursing home residents. AHS will help persons find a PCP. There will be 30-day notices. After 60 days, persons will be auto-assigned to a PCP. The name of the PCP will appear on the second notice.

Ms. Coleman asked if department staff could meet with network offices of the Centers for Independent Living, so staff might field questions. She recommended meeting with the Illinois Network of Centers for Independent Living (INCIL).

Bureau of Healthcare Quality Improvement staff, Stephanie Hanko, gave an update on the Disease Management component, Your Healthcare Plus. The vendor, McKesson Health Solutions, is notifying provider groups about the program. They are starting to do preliminary assessments of persons appropriate for the disease management program. Enrollment is voluntary. The 3 target groups for disease management are: 1) persistent asthmatics; 2) persons with chronic conditions but not receiving Medicare; and 3) person with excessive use of the emergency room in non-emergency situations. McKesson has started working with the persistent asthmatic group. They are focusing on the highest users that represent about 2% of the target population. Mary Miller added that McKesson has about 70 staff to do outreach. Staff includes nurses, pharmacists and caseworkers in 20 catchment areas.

V. Old Business

All Kids and FamilyCare update. Enrollment statistics through May 31, 2006 were provided by Theresa Wyatt.

Robyn Gabel suggested that the department simplify the reporting by not reporting individual numbers for phases I, II and III for All Kids and also to combine the FamilyCare reporting to a one line entry. Ms. Wyatt advised that the department would look at doing this.

Medicare Part D. Sinead Madigan, Bureau of Pharmacy Services Chief, gave a Medicare Part D update. She stated that Part D open enrollment begins on November 15th. There is also continuous enrollment as persons age into Medicare.

In August, the Social Security Administration (SSA) will do redeterminations for persons receiving Extra Help. Some redeterminations will be passive in that the participant will respond only if anything has changed. SSA will also perform redeterminations requiring people who are randomly selected to complete an Extra Help application.

Chairman Pick asked about the payment to providers for participants enrolled in the prescription drug program who needed prescriptions filled for drugs that were not on the formulary. The providers were told there was a 90-day waiver to cover non-formulary prescriptions. Facilities are being charged for medications and want an update to determine if providers will be paid.

Ms. Madigan stated that the department would look into this.

VI. New Business

Ms. Ellinger reported on the citizenship documentation issue. She stated that a little known change in the Deficit Reduction Act says states will get FFP (Federal Financial Participation) for persons declaring to be citizens only if proof of citizenship is provided. That means states may no longer accept declaration of citizenship.

The Secretary of the U.S. Department of Health and Human Services (DHHS) has filed interim final rules that are far more restrictive and complex than required by the Deficit Reduction Act. The governors of California and Ohio have said they would not implement the rule change. Governor Blagojevich sent a letter to DHHS Secretary Leavitt at the end of June advising that we would make a "good faith effort" to implement the rule, but would not harm any beneficiary that could not comply. To our knowledge there has not yet been a response to the Governor's letter.

The rules were promulgated as interim final and were effective on July 6, 2006. The rule of interest is in Volume 71 – 133, starting at 39214. Ms. Ellinger encouraged members to give comments to CMS by August 11.

Ms. Ellinger has found the paperwork reduction rules to be ludicrous in that the federal estimate is that this new requirement will only add a few minutes of time for state staff.

She noted that the rule excludes persons who receive Medicare. This helps although we still have 10,000 persons in nursing facilities that do not receive Medicare.

For persons receiving Supplemental Security Income, states can use Social Security information to determine place of birth. This should help DHS and HFS to document eligibility for SSI recipients. DHS will need to do a programming change to implement the new requirements.

According to the rules, individuals must show original documents. They may not be copies, even notarized copies. The state must have a hard copy in the case record. CMS initially would not take electronic documents but now is considering doing so.

Primary documentation is a passport, certificate of citizenship or certificate of naturalization. Both identity and citizenship are covered by these documents. If another document is used to establish citizenship, then a second document is needed to establish identity. Illinois expects many applicants and recipients will use a driver's license or State identification card to show identity. HFS does not want persons to send original documents. While "face to face" contact is not required, the rule appears almost to require it. There is no leeway for a person that can't prove who they are. Persons with disability or cognitive impairment are at risk. The rule is harmful to frail or disabled persons and is very harsh as written.

Illinois had stopped asking for birth certificates for children as part of application simplification.

CMS has directed states not to enroll persons without documents. HFS questions why the state should be at risk of loss of FFP if it meets the documentation requirement retrospectively.

The rule provides that eligibility for recipients may continue for a "reasonable period of time" but has not defined the period. As of this point, Illinois has decided not to refuse enrollment or discontinue enrollment if documents are not provided. Nonetheless, HFS is working to get processes and resources in place to get these birth certificates.

Chairman Pick had understood that affidavits could be admitted as proof.

Ms. Ellinger stated that an affidavit may be used to document citizenship of an adult. However, two individuals must provide affidavits and only one of them may be related to the applicant or recipient. The witnesses must also provide proof of their own citizenship and identity. CMS expects this proof to be used only rarely.

Parents and legal guardians can attest to the identity of children under age 16. HFS expects this will be used frequently for children.

Ms. Coleman noted that there is a national class action lawsuit filed by the Sargent Shriver National Center on Poverty Law. She was aware of the Medicare and SSI exceptions. She has also heard that the birth certificate must be issued within 5 years of birth.

Ms. Ellinger added the kinds of documents that are acceptable are organized in a complicated scheme under the rule. There are levels 1 through 4. A birth certificate is a level 2 document and highly reliable.

Ms. Vandebroek asked if the state knew the number of Illinoisans affected or estimated the cost to comply.

Ms. Wyatt stated that HFS estimates on the order of 1.5 - 1.7 million persons from whom we will have to seek documents. Ms. Ellinger stated that we had not yet estimated the cost.

Ms. Fraggos understood that the state does not plan to disenroll those unable to provide proof. She asked if a policy memorandum had been issued.

Ms. Ellinger stated HFS has provided caseworkers with written policy. HFS will ask participants for documentation if they declare they are citizens.

Ralph Schubert asked if it could be assumed the state is preparing comments. Ms. Ellinger advised that HFS wants to get a draft ready early – thinking by sharing it will help other groups file comments. It will be a more powerful statement if coming from multiple groups.

CMS may exclude foster children; however, it may not be a major issue as DCFS generally has the documents needed.

Ms. Gabel asked how identity is documented.

Ms Ellinger explained that a driver's license, state ID or school ID could be used. Ms. Chan noted that four documents might be needed just to get a driver's license.

CMS requires a parent or legal guardian to sign an affidavit for a child. This may be problematic as many children live with family members that are not legal guardians.

VII. Subcommittee Reports

Long Term Care (LTC). No report for this period.

Diane Coleman shared that an RFP was issued for a "Money follows the person" demonstration project. The project is designed to move persons from an institutional setting into the community. This project could be a way to give more flexibility and choice to individuals in need of some form of long term care.

She stated that IDHS had funded the centers for independent living to help about 1000 persons over the last several years with a similar program, Community Reiteration. Moving the first 900 persons over a 6 year period saved the government about $55 million, according to IDHS figures. In FY'06 IDOA began implementing a similar program for seniors called "Home Again".

Ms. Coleman added that only states may apply for the federal grants. She encouraged the state to do so. She wants the state to be supportive and suggested that the MAC make a recommendation to participate.

Chairman Pick suggested that this be referred to the Long Term Care subcommittee for recommendation and then be brought back to the MAC.

Ms. Wyatt stated that the state is aware of the RFP and is looking into it.

Dental Policy Review (DPR). No report for this period.

Public Education Subcommittee. No report for this period.

Pharmacy Subcommittee Charge. No report for this period.

VIII. Adjournment

Chairman Pick adjourned the meeting at 11:22 a.m. The next MAC meeting is scheduled for September 15, 2006.

Medicaid Advisory Committee
July 21, 2006
All Kids/FamilyCare Report

Enrollment

- Enrollment data is attached. Enrollment data as of 05/31/06:

  a. 1,073,408 pre-expansion children (up to 100% of FPL)
  b. 359,272 pre-expansion parents (up to approx. 35% of FPL)
  c. 5,553 Moms and babies expansion (133% to 200% of FPL)
  d. 74,466 Phase I (100% to 133%) and 42,393 Phase II expansions (133% - 185% of FPL)
  e. 5,553 Phase III (over 185% - 200% of FPL)
  f. 33,043 FamilyCare Phase I (38% - 49% of FPL)
  g. 32,918 FamilyCare Phase II (49% - 90% of FPL)
  h. 48,656 FamilyCare Phase III (90% to 133% of FPL)
  i. 6,797 FamilyCare Phase IV (133% to 185% of FPL)

Web-based application capability

We implemented our web-based application statewide on August 11, 2005. Since then, we have received a total 26,267 web apps: 18,993 from the general public and 10,835 from AKAA's.

	5/31/2005		6/30/2005		7/31/2005		8/31/2005		9/30/2005		10/31/2005	
	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current numbers
Pre-expansion children	1,046,355	1,046,568	1,049,594	1,050,007	1,050,518	1,052,041	1,056,358	1,060,165	1,058,172	1,064,356	1,063,879	1,067,249
All Kids Phase I	66,490	66,499	67,647	67,669	68,804	68,904	69,825	70,158	70,569	71,155	72,522	72,817
All Kids Phase II	38,085	38,088	38,340	38,344	38,607	38,612	38,210	38,196	37,903	37,865	38,184	38,151
All Kids Phase III	3,531	3,531	3,710	3,710	3,865	3,864	3,991	3,984	4,179	4,176	4,342	4,336
Moms and Babies Exp	6,180	6,190	6,234	6,245	6,218	6,246	6,206	6,281	6,133	6,268	6,242	6,318
Pre-expansion parents	349,762	349,899	349,586	349,839	350,119	351,050	351,359	354,003	351,035	355,644	355,346	358,239
FamilyCase Phase I	30,513	30,512	30,790	30,795	30,958	30,969	30,993	31,023	31,020	31,050	30,960	30,964
FamilyCare Phase II	30,887	30,888	31,131	31,135	31,166	31,197	31,581	31,639	31,840	31,936	31,837	31,832
FamilyCare Phase III	40,795	40,795	42,402	42,409	43,752	43,795	45,046	45,127	45,996	46,153	47,102	47,127
FamilyCare Phase IV												
TOTAL	**1,612,598**	**1,612,970**	**1,619,434**	**1,620,153**	**1,624,007**	**1,626,678**	**1,633,569**	**1,640,576**	**1,636,847**	**1,648,603**	**1,650,414**	**1,657,033**

	11/30/2005		12/31/2005		1/31/2006		2/28/2006		3/31/2006	
	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers
Pre-expansion children	1,060,718	1,066,289	1,063,472	1,067,951	1,064,545	1,071,913	1,071,056	1,074,426	1,069,654	1,075,137
All Kids Phase I	73,620	74,051	75,329	75,718	76,792	77,523	79,012	79,381	79,703	80,340
All Kids Phase II	38,375	38,038	38,424	38,402	38,452	38,416	38,526	38,562	38,545	38,579
All Kids Phase III	4,584	4,572	4,719	4,707	4,892	4,874	5,033	5,027	5,220	5,210
Moms and Babies Exp	6,205	6,339	6,215	6,303	6,205	6,359	6,327	6,397	6,175	6,305
Pre-expansion parents	354,164	358,783	357,938	361,098	358,108	363,897	363,324	365,702	362,659	366,421
FamilyCase Phase I	30,788	30,804	30,786	30,789	30,745	30,748	30,623	30,680	30,447	30,525
FamilyCare Phase II	31,427	31,439	31,208	31,218	31,018	31,051	31,029	31,153	31,134	31,327
FamilyCare Phase III	47,656	47,692	48,265	48,272	48,807	48,867	49,309	49,500	49,654	49,959
FamilyCare Phase IV					2,312	2,351	3,512	3,544	4,597	4,638
TOTAL	**1,647,537**	**1,658,007**	**1,656,356**	**1,664,458**	**1,661,876**	**1,675,999**	**1,677,751**	**1,684,372**	**1,677,788**	**1,688,441**

	4/30/2006 Current Numbers	5/31/2006 Current Numbers
Pre-expansion children	1,078,255	1,073,408
All Kids Phase I	73,553	74,466
All Kids Phase II	40,889	42,393
All Kids Phase III	3,246	3,655
Moms and Babies Exp	5,738	5,553
Pre-expansion parents	364,708	359,272
FamilyCase Phase I	32,911	33,043
FamilyCare Phase II	32,851	32,918
FamilyCare Phase III	48,210	48,656
FamilyCare Phase IV	5,633	6,797
TOTAL	**1,685,994**	**1,680,161**