Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
September 17, 2010

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

Members Present
Eli Pick, Chairman
Susan Hayes Gordon
Kathy Chan
John Shlofrock
Mary Driscoll
Melissa Vargas
Judy King
Linda Diamond-Shapiro
Andrea Kovach
Karen Moredock
Jan Costello

Members Absent
Robert Anselmo, R.Ph.
Myrtis Sullivan
Alice Foss
Pam Harris
Edward Pont, M.D.
Renee Poole, M.D.
Sue Vega

HFS Staff
Julie Hamos
Theresa Eagleson
Jacqui Ellinger
Jim Parker
Barb Ginder
Amy Harris
Stephanie Hoover
Ann Lattig
Lynne Thomas
Robyn Nardone
James Monk

Interested Parties
Elaine Schmidt, DCFS
Martha Wright, Comprehensive Bleeding Disorders, Peoria
Bonnie Schaafsma, IL Assn of Public Health Administration, Kankakee County Health Dept.
George Hovanec, Consultant
Diane Rucinski, UIC
Roy Pura, Glaxo Smith Kline
Teresa Hursey, IHA
Joe Ourth, Arnsteia & Lehr
Kendig Berstressen, Abraxis Bioscience
Joseph Turner, DHS DDD
Gary Fitzgerald, Harmony Health Plan
Robin Scott, Chicago DPH
Elizabeth Brunsvold, Med Immune
Mary Capetillo, Lilly
Mike Lafond, Abbott
Kathy Bovid, Bristol Myers Squibb
Martin Mathews, Merck & Co
Victoria Bigelow, Access to Care
John Bullard, Amgen
Gerri Clark, DSCC
Lora McCurdy, IARF

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I. Call to Order

Chairman Pick called the meeting to order at 10:06 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves. Kathy Chan, Melissa Vargas, Judy King, Andrea Kovach, Jan Costello and Linda Diamond-Shapiro were introduced as new MAC members.

III. Review of the Minutes

The June minutes were not approved so that information regarding DM savings could be checked. Revised minutes will be reviewed at the next meeting.

IV. Director's Report

HFS director, Julie Hamos, provided the report.

Health Care Reform

Extension of FMAP
Congress extended the enhanced FMAP from January 2011 through June 2011. The reimbursement rate will be phased down from 62% beginning in January 2011. The department expects to receive about $500 to $550 million and anticipates a shortfall of $200 to $250 million.

Illinois Health Reform Implementation Council
The Illinois Health Reform Implementation Council, created by Governor Quinn under Executive Order 10-12, will have an informational outreach meeting on September 22nd at 6:00 pm in the auditorium at the JRTC building. The council will set up workgroups according to interests expressed at the meeting.

Medicaid and Health Reform
Director Hamos provided the committee with an overview of the presentation on *Medicaid and Health Reform* (Attachment 1) that she had given to the Human Services Commission on September 14, 2010.

There was some discussion that in the development of new quality standards, we may see movement to the development of national standards.

Melissa Vargas asked if dentistry fits in with delivery reform; and specifically will reform include routine dental care for adults. Deputy Administrator, Jim Parker, advised that dentistry does fit in and that outcome measures will be requested from the vendor.

Robin Scott asked if there would be time to talk about the Medicaid expansion. Director Hamos advised that there would be more hearings on the expansion.

Judy King stated that mental health providers have expressed concern about how they would be impacted and asked if individuals be required to enroll with an integrated care organization and if mental health providers will be connected. Director Hamos responded that the community mental health services will be integrated. She stated that the system is too fragmented and there is a need for better care integration.

Other Updates

Integrated Care (IC) Program
Last week the department announced that Aetna and Centene-IlliniCare had been awarded contracts through the RFP process for the Integrated Care Program. The IC program starts a new era of case management that will keep people healthy through more coordinated better care, thereby saving avoidable, unnecessary healthcare costs. Phase 1 of the program will include the traditional Medicaid services. Phases 2 and 3 will expand the program to include other services, including long term care and home and community based waiver services. The care integration focus of the IC Program was set in place beginning in July 2010 by engaging stakeholders to identify quality of care and quality of life measurements. The time table for implementation is to finalize the contracts this fall, with the vendors beginning to enroll participants in January. Hopefully, Phase 2 will begin within one year.

Mary Capetillo asked if pharmacy benefits are included. Theresa Eagleson, Administrator of the Division of Medical Programs, stated that although it wasn't included in the original RFP, it was added later as an optional service for which the contractors may choose to cover.

Jan Costello asked if there will be an effect on home health and hospices. Ms. Eagleson stated some effect but it will involve only a small number of participants.

Director Hamos stated that the department will encourage providers to reach out to the contractors. Chairman Pick recommended that the department list contractor contact information on its' Web site.

V. Old Business

1) **All Kids and FamilyCare update.** Theresa Eagleson indicated that the department is moving to a new total enrollment report format that will ultimately be available on the HFS Web site. She suggested that, if the committee preferred, a paper report could be provided as part of the meeting material, rather than a verbal report being given at the meeting. The suggestion was accepted.

Lynne Thomas, Chief of the Bureau of All Kids, reported that the application processing time is creeping up and currently at 36 days. This is a little higher than this time last time and is a result of increased volume.

Ms. King stated that she was interested in Medicaid enrollment for adults and had some concern for adult enrollment processing time across programs. Ms. Thomas noted that the processing time for FamilyCare adults is the same as the processing time for All Kids. Deputy Administrator, Jacqui Ellinger, stated that the department could explore creating a combined DHS/HFS report sheet.

2) **Primary Care Case Management (PCCM).** Amy Harris, with the Division of Medical Programs, provided the update. She reviewed the handout showing the number of medical homes and client enrollment numbers (Attachment 2). She advised that the department normally receives about 70,000 to 75,000 phone contacts per month. In August approximately 85,000 calls for connecting with a PCP were received, with the increase primarily being related to back to school medical needs.

The handout "2009 Illinois Health Connect Bonus Payment for High Performance program Summary" was reviewed (Attachment 3). Ms. Harris advised that bonuses went out only to providers that met the department's benchmarks and noted that there was an increase in bonuses over last year.

Jim Parker noted that the medical home numbers were relatively stable. He proposed that the handout be provided without a verbal report. He stated that annually the department would review the report as there would be new summary data.

Ms. King would like to have handouts sooner before the MAC meeting. Mr. Parker stated that he would prefer that handouts would go out before the meeting and be posted on the Internet. The plan would be to not reprint old handouts but have more copies of new handouts available before the meeting. Jacqui Ellinger noted that the Open Meetings Act requires that the meeting agenda be posted at least 48 hours prior to the meeting and that the department tries to send the agenda out a week ahead of time.

Ms. King asked what measures are being taken to increase compliance for breast cancer screening. Director Hamos responded that the department was pulling an action plan together for October, 2010 which is Breast Cancer Awareness month.

Ms. King noted that only HEDIS indicators for developmental screening and breast cancer were shown at the last meeting. She would like to see all HEDIS measurement used by the department.

Chairman Pick would like an inventory of all measurements so that the committee may then do an assessment of these and make a determination if the list is comprehensive. Director Hamos agreed that it would be important to assess the PCCM and DM indicators as these program contracts will soon expire.

Disease Management (DM): There was no new update for today. Director Hamos advised that the DM contract expires in eight months. Chairman Pick recommended that the committee review what the DM program has achieved over the lifetime of the project and determine where the department would like to go from there.

Ms. King asked if there is a new External Quality Review Technical Report available. Deborah Saunders, Chief of the Bureau of Maternal & Child Health Promotion, stated the report is in final review and should be available soon.

VI. New Business

1) **Children's Healthcare Quality Initiatives.** Ms. Saunders reviewed a PowerPoint handout "Quality Improvement – Child Health" prepared for the MAC meeting (Attachment 4). The handout, "CHIPRA Measures – Illinois" and the brochure, "Illinois DocAssist" were also provided and discussed.

2) **Review of By-Laws**
Participants were provided a copy of the MAC by-laws (Attachment 5). Director Hamos suggested that the committee extend the offices of Eli Pick as Chair and Susan Hayes Gordon as Vice-Chair through the end of the current fiscal year, June 30, 2011. A motion to extend the two offices was made and passed by the committee.

3) **2011 Meeting Dates**
Director Hamos stated that the department would like the MAC to continue to meet quarterly and on the third Friday of the month. She stated that the new meeting dates for 2011 would be posted on the MAC Website. No objection to keeping this schedule was raised.

4) **Open to Committee**
Ms. King would like to look at what the committee will be doing and the direction the committee would be going. She advised that it would be helpful to discuss what topics go on the agenda and what the agenda categories should be. She suggested a special meeting to discuss what the committee wants to know and how to proceed. The committee should not just be reacting to the department agenda.

Vice-Chair Gordon stated that the MAC is an advisory committee serving at the request of the director. She added that maybe the committee could rearticulate goals and have more time to review items to be a better sounding board. Mary Driscoll added that it would be a good idea to reiterate the purpose for the committee to advise the director and to determine the best way to serve.

Chairman Pick advised that he was not in favor of more subcommittees. He acknowledged that much of the committee agenda is legislatively driven and a reactive

process. He suggested that perhaps the committee could identify gaps that are of interest to members' constituents.

Andrea Kovach expressed interest in getting documents as far in advance as possible for better discussion.

It was summarized that the committee would like to see handouts in advance of the meeting and to see inventory of the quality measures for the PCCM and DM programs.

VII. Subcommittee Reports

Long Term Care (LTC)

Deputy Administrator, Barb Ginder, provided the report. She stated that the subcommittee met on September 10, 2010. Topics discussed included:

- Overview of Proposed Long Term Care Eligibility Rule Changes
- Impact of Extension of Enhanced FMAP on HFS FY11 Budget
- MDS 3.0 Implementation and Impact
- Implementation of Nursing Home Safety Legislation (P.A 96-1372)
- Money Follows the Person (MFP)
- Supportive Living Facility (SLF) Solicitation Dementia Care Pilot and 22-64 with Physical Disabilities Status Report
- Integrated Care RFP

The next LTC subcommittee meeting is scheduled for December 17, 2010.

Public Education Subcommittee

Jacqui Ellinger reported that the next workgroup meeting is September 30, 2010. Agenda items include following up on the American Community survey, MaxEnroll project and change to a permanent medical ID card.

Pharmacy Subcommittee

No report for this period.

VIII. Adjournment

The meeting was adjourned at 12:20 p.m. The next MAC meeting is scheduled for November 19, 2010.

Medicaid and Health Reform

Human Services Commission

September 14, 2010

Illinois Department of Healthcare and Family Services

Overarching Purpose

- The main purpose of the Affordable Healthcare Act (ACA) is to create affordable, high quality healthcare for all citizens.

- To address the intent and spirit of this law, Medicaid must continue to transform itself from an agency whose primary purpose is to process claims, to an agency that proactively works to keep Medicaid clients healthier.

- Providing quality care that keeps people healthier will reduce avoidable, unnecessary and unsustainable healthcare costs.

Structure of Health Reform

ACA addresses its purposes in two major areas

- ***Improve Access — through Insurance Reform***
  - Key changes in overall market—elimination of pre-existing condition clauses, prohibition of rescission, children coverage to age 26, more regulation of insurance offerings, review of medical loss ratios and others
  - Health Insurance Exchanges for purchase of insurance and eligibility for subsidies based on income
  - Medicaid expansion with income-based eligibility for all citizens with income less than 133% of the Federal Poverty Level
- ***Reform Delivery Systems — especially Medicare and Medicaid***
  - Multiple incentives, mandates, options & demonstrations
  - Banking on leverage of government systems to influence entire market

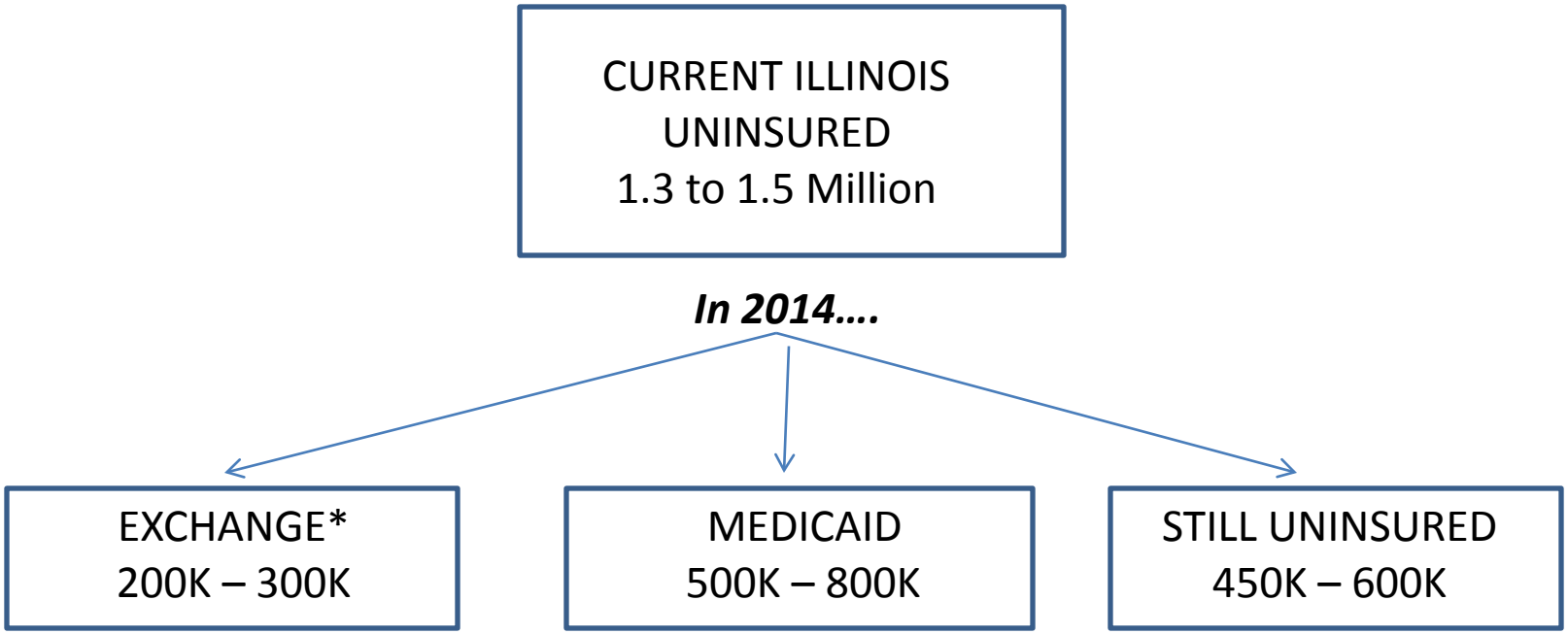
Structure of Health Reform in Illinois

In Illinois, different agencies have lead responsibility for different parts:

- ***Insurance Reform***
  - Regulate changes in insurance market — *Dept. of Insurance*
  - Create Health Insurance Exchanges — *Dept. of Insurance*
  - Expand Medicaid — *HFS (with major DHS implications)*
- ***Service Delivery Reform***
  - HFS has lead responsibility, but many other agencies, particularly DHS, DPH and Aging, are involved
- ***Coordination*** of all efforts through *Governor's Healthcare Reform Implementation Council*
  - 10 agencies are involved

Expansion of Medicaid Eligibility

The most immediate responsibility of the Medicaid program in Health Reform is to be able to enroll a large number of new recipients in a relatively short time starting in late 2013.



** 200K – 300K is only currently uninsured estimated to receive coverage from Exchange; larger portion of people receiving coverage through Exchange are currently with small employers, buying individual coverage, and otherwise now able to find some insurance.*

Expansion Is Formidable Challenge

- Existing systems and processes are ill-suited to enrolling a large number of people in relatively short time frame
- Will need robust outreach effort that is coordinated with the Exchange to get people to the right program
- Outreach effort will identify a number of people who were already eligible for Medicaid and those will adversely impact the budget since only newly eligible people receive the enhanced Federal match

Existing Systems Cannot Meet Needs

- Current system at DHS more than 30 years old — all changes very difficult
- Requires substantial manual intervention
- Very paper intensive, e.g. requires physical storage of key data elements rather than electronic records
- Limited ability to interact with other electronic databases and not sure how it would interact with Exchange
- Limited ability to accept and deal with electronic client applications—although some states receive majority of applications that way
- DHS offices beyond capacity to deal with hundreds of thousands of new enrollments (and redeterminations) on site

Response?

- Obsolescence of existing system well known—Framework project would replace that system (among other things)
- Unfortunately, current schedule for Framework insufficient—does not project an RFP for main vendor until spring 2013
- Anticipate receiving ACA Planning Grant from HHS in October
- Have set aside $300K from this grant to assess eligibility and enrollment issues for newly eligible, in Medicaid and in Insurance Exchanges
  - Determine if it is possible to use existing system
  - If not, analyze all potential alternatives

ACA Eligibility & Enrollment Considerations

System requirements must include:

- Intake for large number of new eligibles in short time period; annual redeterminations of eligibility
- Straightforward transfer of information between Medicaid and the Exchange
- Easy electronic customer application
- One stop shopping for insurance choices — including information about choices
- Sufficiently efficient to be sustainable
- Recognition that some clients' eligibility status may change frequently; coordination with other payers and other plans
- Links to other programs providing governmental subsidies

Plan for Enrollment Systems

- Plan to have Assessment/Planning RFP issued by Thanksgiving with activity starting in January
- Anticipate final report in April
- Governor's Health Reform Implementation Council will determine a course of action and issue RFP(s) by mid-summer
- Need to have vendor(s) aboard and working by fall 2011 to be ready for fall 2013 implementation
- Interim reports and discussions with other oversight bodies and stakeholders will be continuous

Delivery System Reform

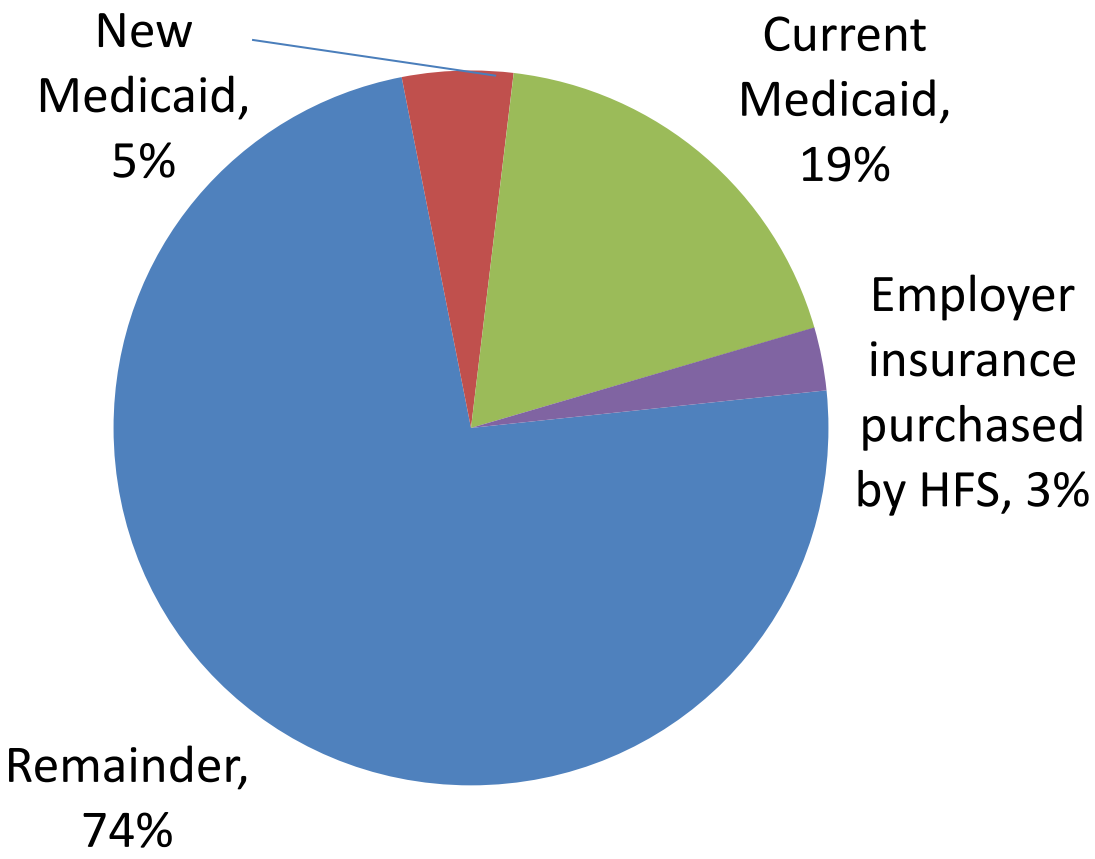
ACA does not offer a prescription for reform; it creates number of options and alternatives to design more effective and efficient delivery systems.

In Illinois, Medicaid will take leadership to reform the healthcare delivery system by:

- Requiring quality and efficiency standards
- Initiating a new era of care management
- Requiring the measurement of health outcomes
- Building capacity of the health system
- Infusing accountability standards at all levels: consumer, providers and the state
- Being an effective purchaser of healthcare

Medicaid Will Be 24% of Market

Medicaid's market position will be sufficient to demand change



Current – Medical Home Network

- About 1.8M Medicaid clients have been assigned to medical homes in the Primary Care Case Management system – called *Illinois Health Connect*
- Over last year have refined system so that clients are more closely tied to their medical home
- Identified five specific activities for providers and have created infrastructure to support these activities, working with our partner, Automated Health Systems
- Last year paid out $3.2M in bonus payments that reflect achievements of desired outcomes

Current – Disease Management

- About 200K clients are enrolled in a voluntary disease management program administered by McKesson Health, about 40 percent of whom have behavioral health diagnosis
- Focus on adults, in and out of institutions, with chronic or complex issues
- Work directly with clients and with providers to integrate care, improve treatment efficacy, and promote appropriate utilization
- In first two years, program participants showed improvement on all 19 care indicators, such as vaccination, smoking status and blood pressure control
- Mixed improvements in appropriate utilization (inpatient, ER, pharmacy); roughly 5% decrease in inpatient in ABD group

Current – Integrated Care Program

- Aetna and Centene-Illini announced as partners in the Integrated Care Program, serving about 40,000 seniors and disabled clients in suburbs and collar counties
- Expect to enroll clients about January 1, 2011
- HFS will involve disability community advocates, social service organizations and labor organizations to help design, monitor and evaluate the program
- First phase will concentrate on traditional medical services; subsequent phases will include long-term care
- Program will reinforce consumer-directed care for disabled clients in the selection and hiring of personal assistants
- Program will have independent evaluation by UIC, managed by Illinois Department of Public Health

Integration Is Key

- Better integration of care is the only way to improve quality *and* efficiency, especially for people with complex, special needs
- Providers must have stronger incentives to use professional expertise to determine what services provide highest quality in an efficient manner:
  - Physicians are not now responsible for hospitalizations, use of specialists, or the amount of diagnostic testing
  - Hospitals are only minimally responsible for re-hospitalizations
  - Nursing homes have no incentive to move people to community settings

Moving Forward: 8 Strategies to Reform Medicaid

1. Expand and strengthen the medical home network
2. Test new models of care management: e.g. integrated care, accountable care organizations
3. Strengthen home- and community-based service infrastructure to reduce reliance on institutional care
4. Expand prevention and wellness strategies, based on best practices
5. Test new payment systems to incentivize quality outcomes: e.g. bundled payments, pay-for-performance, capitated rates
6. Partner with other payers to coordinate provider incentives
7. Implement electronic medical records to enable coordination of care and measurement of outcomes
8. Expand pipeline of primary care physicians, specialists, other health care professionals serving Medicaid clients

Home- and Community-Based Service Infrastructure

- ACA has additional flexibility for home- and community-based services and creates new options for Medicaid
  - State plan options for home and community-based services, rather than waivers
  - Extension of *Money Follows the Person* rebalancing
- Expanded service infrastructure needed to serve clients with severe, complex needs in home and community settings
  - Comprehensive pre-admission screening
  - Comprehensive services and care coordination
  - Improved systems for tracking and case management
  - Quality assurance mechanisms
  - Appropriate incentives to focus on holistic needs of clients
  - Available long-term care/housing options

Public Input

- Governor's Health Care Reform Implementation Council, created by Executive Order, will hold hearings this fall and submit first report by December 31, 2010
  - September 22, 4 to 6 PM in auditorium of JRTC
  - November 16, 4 to 6 PM in Springfield
- Health Care Justice Implementation Task Force (SB 3047)
  - Amendatory veto with delayed effective date
  - Will hold public meetings
- Healthcare Reform Implementation website will be launched in several weeks (healthcarereform@illinois.gov)
- Will work with appropriate stakeholders around design and evaluation of specific reforms — as HFS is doing with the Integrated Care Program

Statewide Medical Homes and Client Enrollments as of September 13, 2010

Number of Medical Homes*	Panel Size	Eligible Client Count	Clients Enrolled in IHC	Clients Enrolled in MCO	Total Clients with a Medical Home
5,665	5,454,941	2,063,562	1,805,633	193,552	1,999,185

* FQHC/RHC/ERC Sites are counted as 1 Medical Home

2009 Illinois Health Connect Bonus Payment for High Performance Program Summary

(Includes 2008 Bonus Program Results)

Program Summary

Of the 4,897 unique providers/sites that could qualify for a bonus under the 2009 bonus payment program, 4,248 qualified (received a bonus) for one or more bonus measurement at one or more site. This means over 88% of all eligible PCPs will receive a bonus for 2009. In total, 4,567 sites will receive a bonus. The bonus payment for each qualifying event under the 2009 Bonus Program is $25.00. A total of $3,312,400 will be paid to qualifying PCPs/Sites under the 2009 Bonus Program.

All bonus payments for 2009 were issued by mail to the PCPs payee the week of July 19, 2010. PCPs can access patient specific detail of their bonus payments via the Illinois Health Connect Provider Portal through HFS'secure MEDI system.

Under the 2008 bonus program, bonus payments were issued to 4,123 qualifying providers at 4,430 sites. The bonus payment for each qualifying event under the 2008 Bonus Program was $25.00 and a total of $2,896,125 was paid to qualifying PCPs/Sites.

Quality Measurement Summary

For the 2009 program, HFS looked at 389,610 unique clients under all 5 bonus measurements. For these clients there were 236,535 eligible events. Of these eligible events, 132,496 qualified for a bonus.

Under the 2008 program, HFS looked at 362,050 unique clients under all 5 bonus measurements. For these clients there were 197,071 eligible events. Of these eligible events, 115,845 qualified for a bonus.

2009 Bonus Program		
Measurement	**Qualifying Recipients**	**Bonus Value**
Asthma Mgmt	19,118	$477,950
Breast Cancer	13,055	$326,375
Developmental Screening	66,115	$1,652,875
Diabetes Mgmt	14,077	$351,925
Immunizations	20,131	$503,275
Totals	**132,496**	**$3,312,400**

2008 Bonus Program		
Measurement	**Qualifying Recipients**	**Bonus Value**
Asthma Mgmt	18,730	$468,250
Breast Cancer	11,667	$291,675
Developmental Screening	55,272	$1,381,800
Diabetes Mgmt	10,128	$253,200
Immunizations	20,048	$501,200
Totals	**115,845**	**$2,896,125**

HFS MAC Meeting

Quality Improvement - Child Health

September 17, 2010

Overview: CMS

- Right Care for Every Person, Every Time
- CMS Recently Developed a Medicaid/CHIP Quality Strategy
  1. Evidence-Based Care & Quality Management
  2. Payment Aligned with Quality
  3. Health Information Technology
  4. Partnerships
  5. Information Dissemination, Technical Assistance, & Sharing Best Practices

Overview: Illinois

- Illinois HFS Focus on Access to Care & Quality
  - Medical Home Initiative (PCCM – IHC)
  - Managed Care Organization – Strengthening of Contracts Requiring Quality Assurance, Measurements & PIPs
  - Partnerships with Professional Organizations & Community Groups to Improve Content of Care & Referrals Connections
  - Partnerships & Data Sharing
  - Ongoing Quality Monitoring (Measurements)
  - Access to Administrative Data, Provider Feedback, Panels, Profiles
  - Access to Psychiatric Consultation Lines (DocAssist, Perinatal Depression)
  - Focus on Oral Health for Children
  - Bonus Payment Strategies

Early & Periodic Screening, Diagnosis & Treatment (EPSDT)

- Healthy Kids: Illinois' Preventive Program
- Two Mutually Supportive Goals
  - Assuring the Availability & Accessibility of Covered Healthcare Services Through a Medical Home
  - Helping Program Participants Use Healthcare Services
- Four Categories of Preventive Health
  - Medical/Health
  - Vision
  - Hearing
  - Dental

Early & Periodic Screening, Diagnosis & Treatment (EPSDT)

- Periodicity Schedule
  - 6 Visits Under Age 1
  - 4 Visits Between Ages 1-3
  - Annually Between Ages 3-6
  - Every Other Year Between Ages 6-21
  - As Frequently as Medically Necessary
- Annual FFY Reporting (CMS-416)
- HEDIS/HEDIS-like Reporting
- Quality Measurement Monitoring – Dental
- Performance Improvement Strategies
  - Bonus Payments, Provider Training, In-Office Detailing, Technical Assistance, Access to Data, Profiling, Consultation Services

Quality Improvement Initiatives

CHIPRA
Child Health Quality Demonstration Grant

- 5 Year Demonstration Project – Partnering with Florida (Florida – Lead)
- Priority Areas:
  - Category A – Core Child Health Measures (24)
  - Category B – HIE/HIT
  - Category C – Strengthening the Medical Home
  - Category E – Improving Perinatal Health Outcomes

(See Handout)

ABCD III

- Improving Care Coordination, Case Management & Linkages to Support Healthy Child Development
- Illinois Healthy Beginnings
- Funded by the Commonwealth Fund & FFP
- Administered by NASHP
- Partners with ICAAP, Ounce of Prevention, & Others
- Collaborative with 4 Other States (OR, OK, MN, AR)
- 3 Subcommittees (Service Data Integration, Referral & Resource, Support to Families At-Risk)
- Focus on Developmental Screening & Coordination with Early Intervention
- Pilot Communities (TBD)

Enhancing Developmentally Oriented Primary Care (EDOPC)

- Funded by the Michael Reese Health Trust, Illinois Children's Healthcare Foundation, FFP & Others
- Administered by Advocate Charitable Foundation
- Partners with ICAAP, IAFP, & Others
- Many Goals – Improving Delivery & Financing of Preventive Health & Developmental Services for Children Birth to Three
  - Educational Programs (Online Courses, Office-Based Presentations, Teleconferences)
  - Ongoing Technical Assistance
- Connects with State Systems & Resources (e.g. Early Intervention, State Database/Resources, Consultation)

PSYCHIATRIC CONSULTATION

- **DocAssist** – www.psych.uic.edu/DOCASSIST (See Brochure)
- **Perinatal Depression Consultation Service** - http://www.psych.uic.edu/research/perinatalmentalhealth/ (See Brochure)
  - Connection to NorthShore Client Crisis Hotline
- Components
  - Behavioral Health Telephonic Consultation
  - Provider Education & Training
  - Medications Chart Education
  - Website
  - Psychotropic Prescribing Practices Review
  - Outreach & Marketing
  - Referral Connection to State Database (DCFS' GeoAccess Referral Resource System)
- Partners: DHS, Illinois Children's Mental Health Partnership, Voices for Illinois Children, UIC

DENTAL

- DentaQuest – Administrator
  - Administrative: Timely processing and payment of claims, prior approvals
  - Client: Education, EPSDT outreach and customer service, referral for dental care
  - Provider: Education and recruitment
  - New *Windward* system with improved capabilities for providers, including ability to submit X-rays electronically and easier eligibility look-up, and real-time claim adjudication
- All Kids School-Based Program – Quality Improvement
  - Referral system requirements, case management
  - Improved quality standards, physical requirements, provider/student ratios
  - Monitoring of score of "2" (have decayed teeth needing either fillings or crowns) and score of "3" (need urgent treatment for advanced dental disease including signs or symptoms of pain, infection, exposed nerve, or swollen, bleeding gums) – follow-up correspondence and referral for care
- Local Health Departments
  - Federal claiming
- Bright Smiles From Birth
  - Collaborative—AAPD, ISDS, IDPH, HFS, ICAAP, IPHCA, ICHF
  - Fluoride varnish application by medical providers trained by ICAAP
  - Three applications a year, for under 3
  - Pilot in Cook County; expansion

MCO PIP

- Asthma (Retired, Achieved Goals)
- Well-Child Visits
  - Content of Care for Children Under Age 3
  - Focus on Referrals
- Perinatal Care
  - Prenatal & Postpartum (HEDIS)
  - Perinatal Depression
  - Focus on Referrals & Care Coordination
- Behavioral Health
  - Focus on Coordination Between Medical & Behavioral Health
  - Baseline 2010

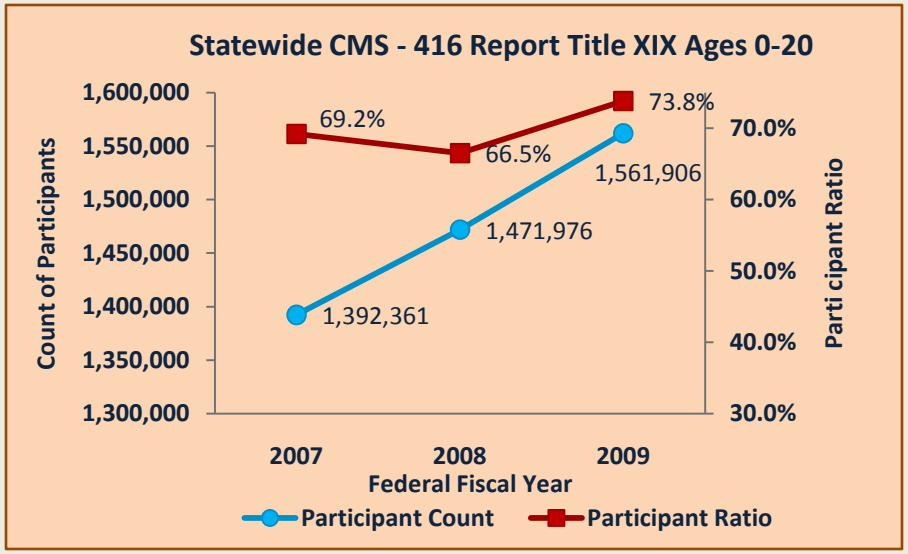
Data

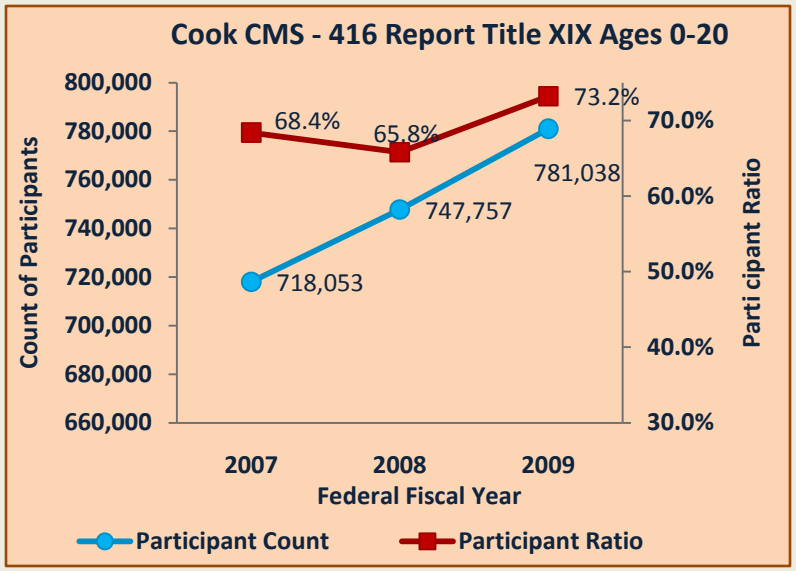
CMS 416

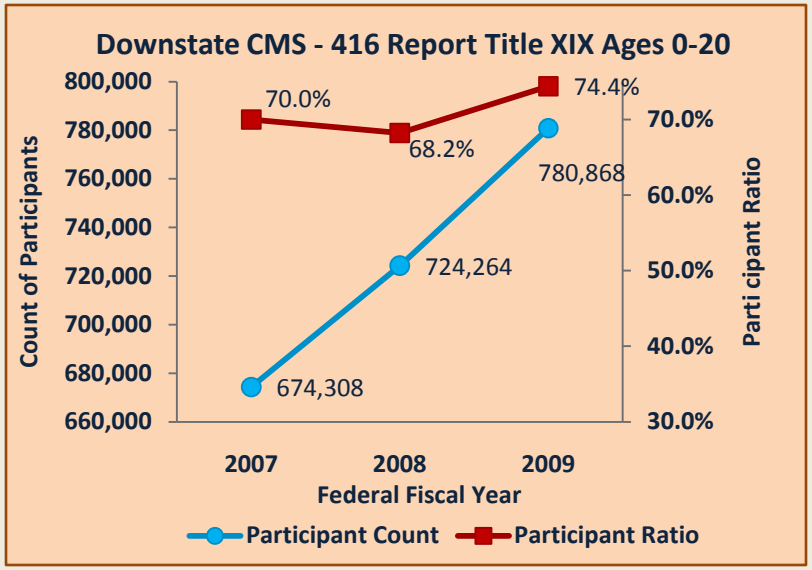
- Reported Annually to Centers for Medicare & Medicaid Services (CMS) for Title XIX
  - Available for *AllKids*
  - Available for Cook & Downstate
- Federal Fiscal Year Reporting
- Adjusted Participation Rate Based on Population, Periodicity Schedule, & Member Months
- National & Comparisons of Other States

http://www.cms.gov/medicaidearlyperiodicscrn/03_stateagencyresponsibilities.asp

CMS 416: FFYs 2007, 2008, 2009







IMMUNIZATIONS

- Combo 2
  - 4 DTaP
  - 3 IPV
  - 1 MMR
  - 2 Hib
  - 3 Hep B
  - 1 VZV

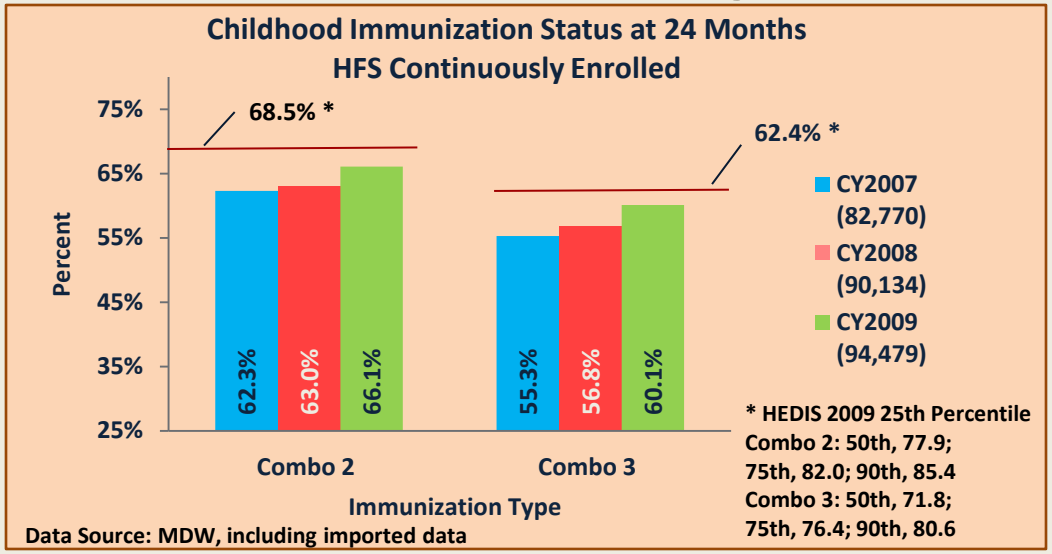
- National – 72.9*
- Illinois – 71.6*

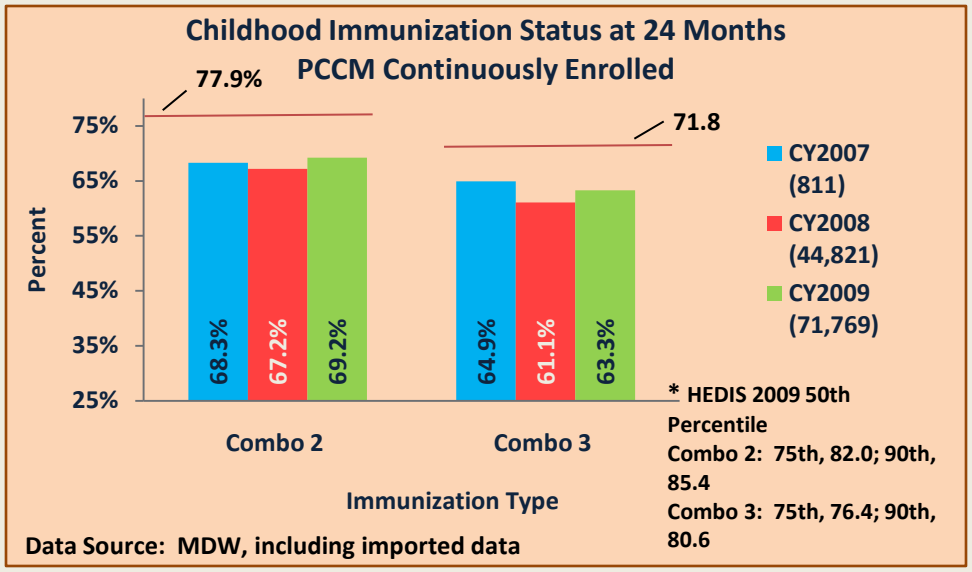
- Combo 3
  - 4 DTaP
  - 3 IPV
  - 1 MMR
  - 2 Hib
  - 3 Hep B
  - 1 VZV
  - 4 Pneumococcal Conjugate

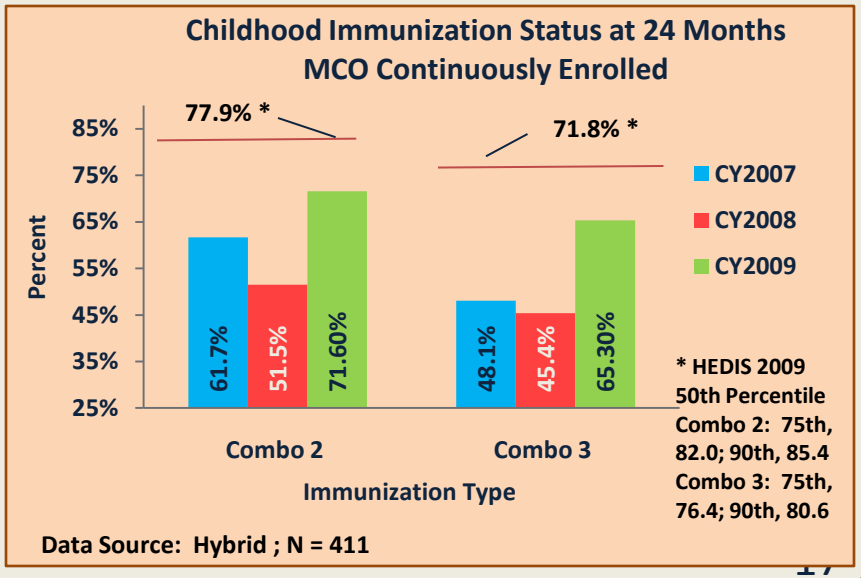
- National – 65.7*
- Illinois – 64.1*

* CDC Survey Information 2008

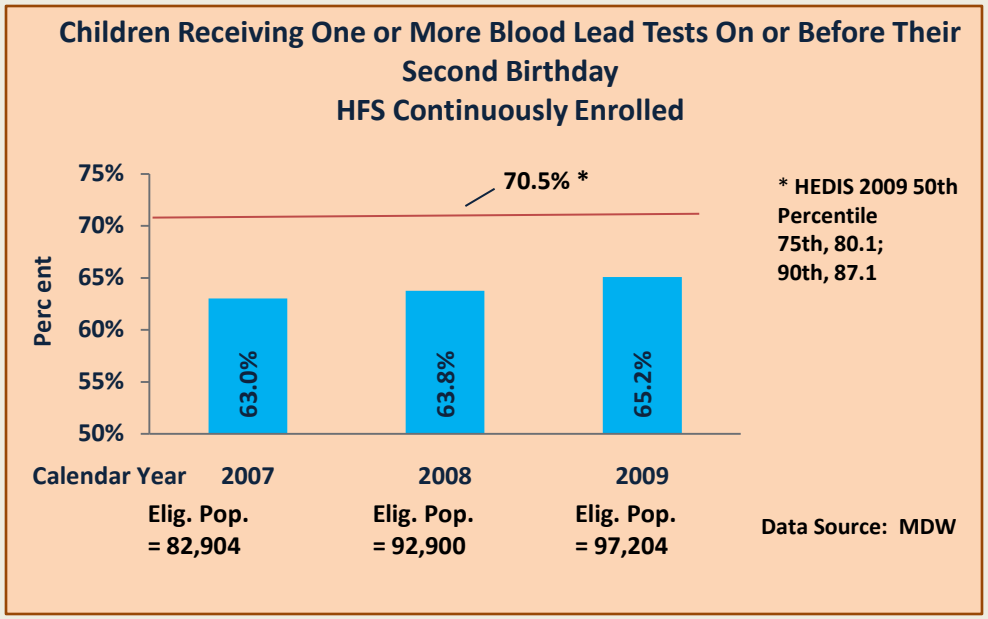
IMMUNIZATIONS: By 24 Months

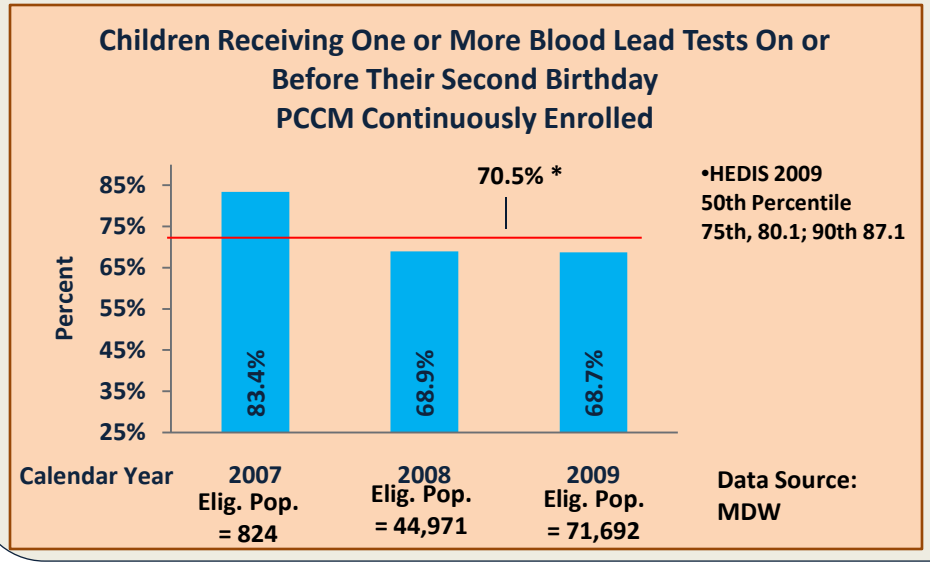


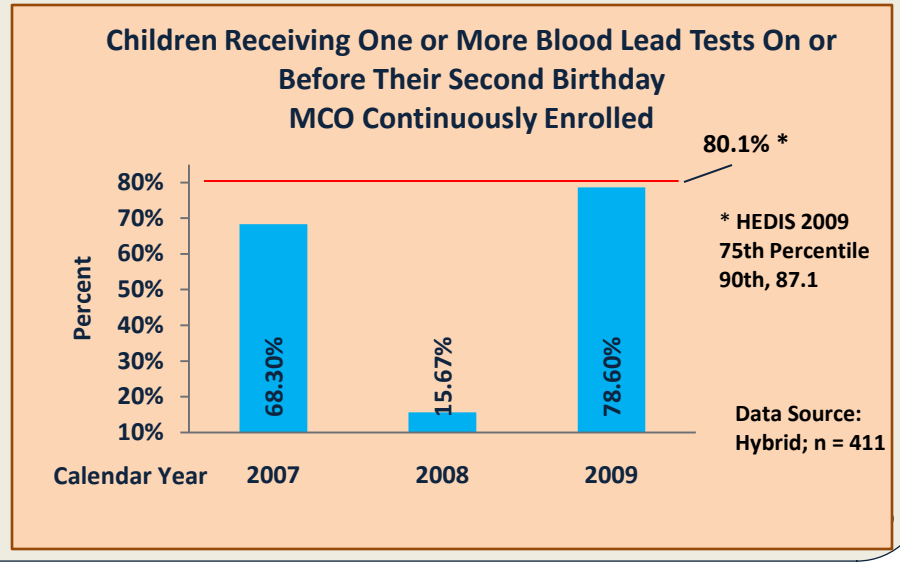




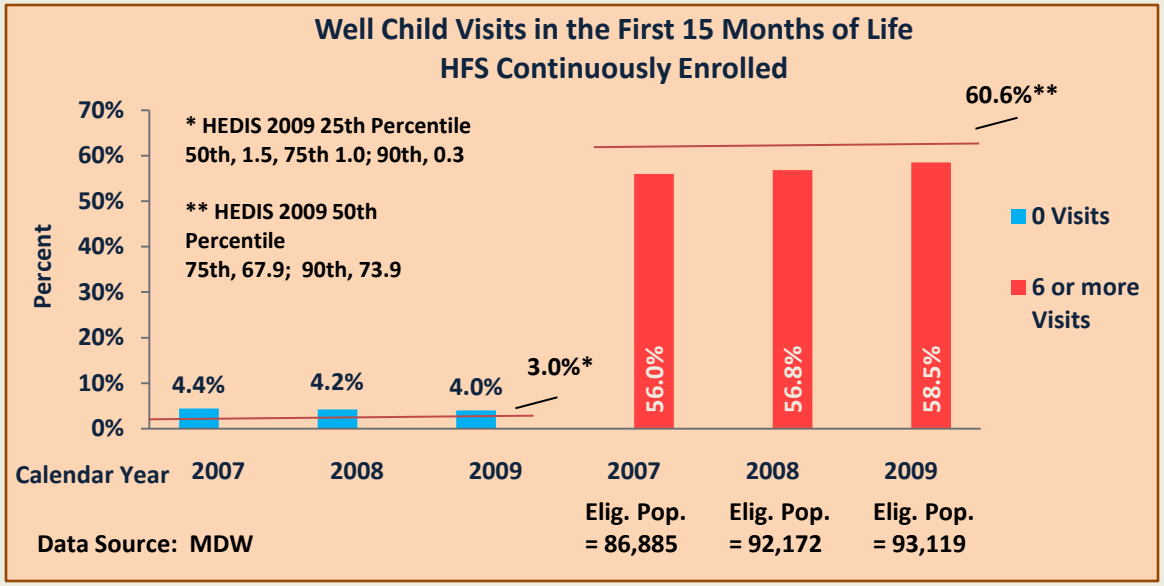
LEAD SCREENINGS: Before 24 Months

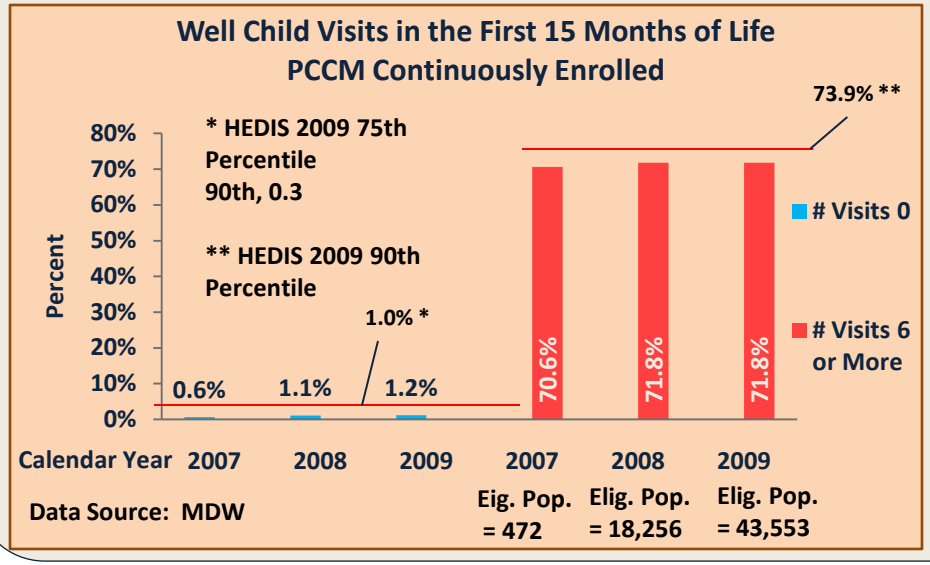


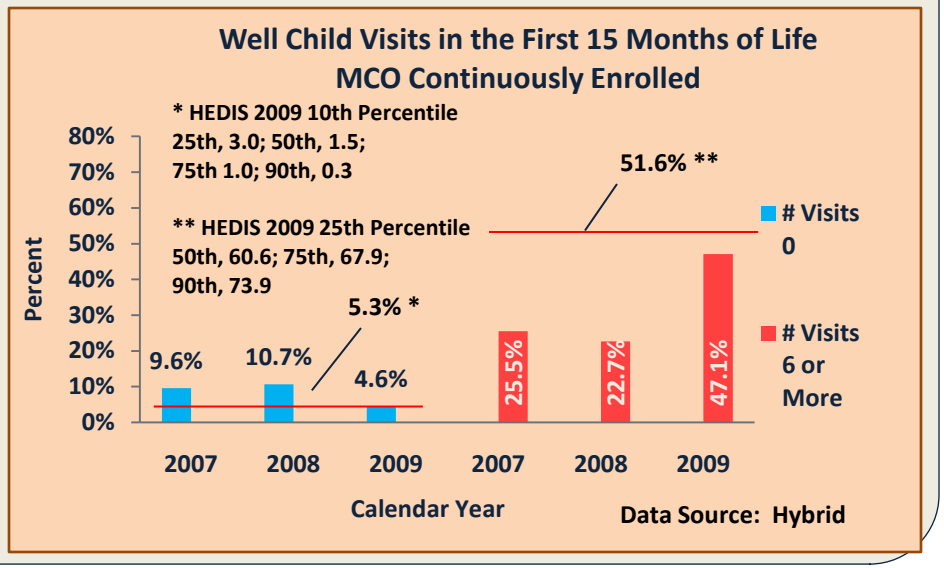




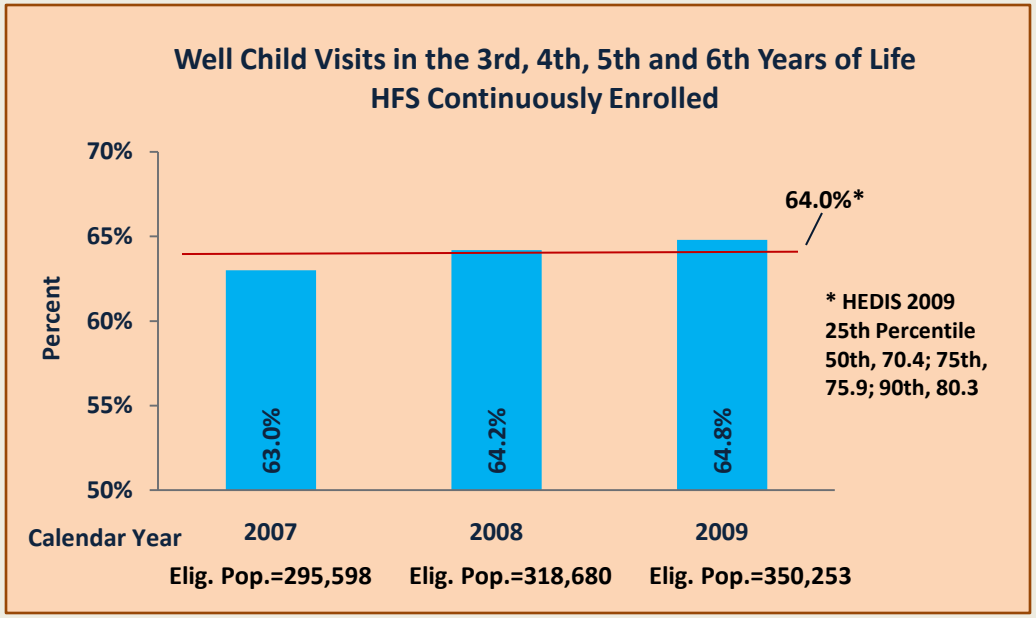
WELL CHILD VISITS: 15 Months

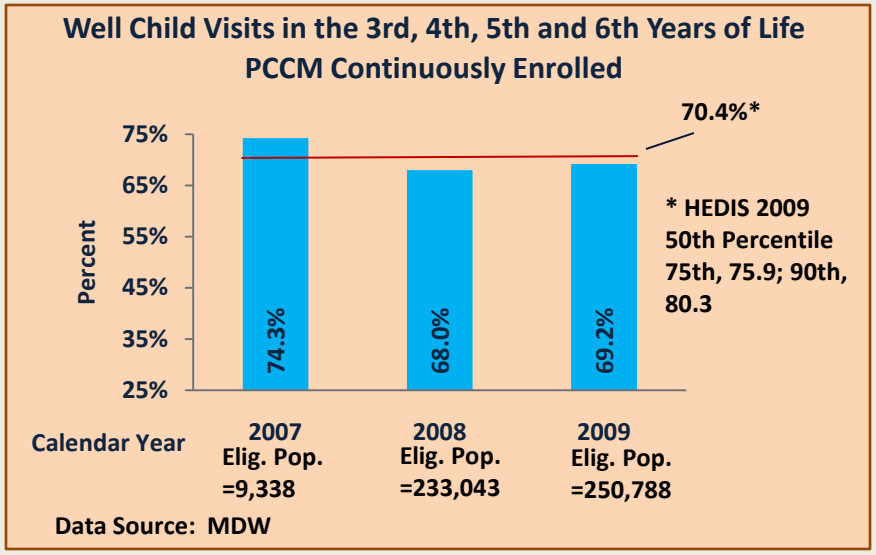


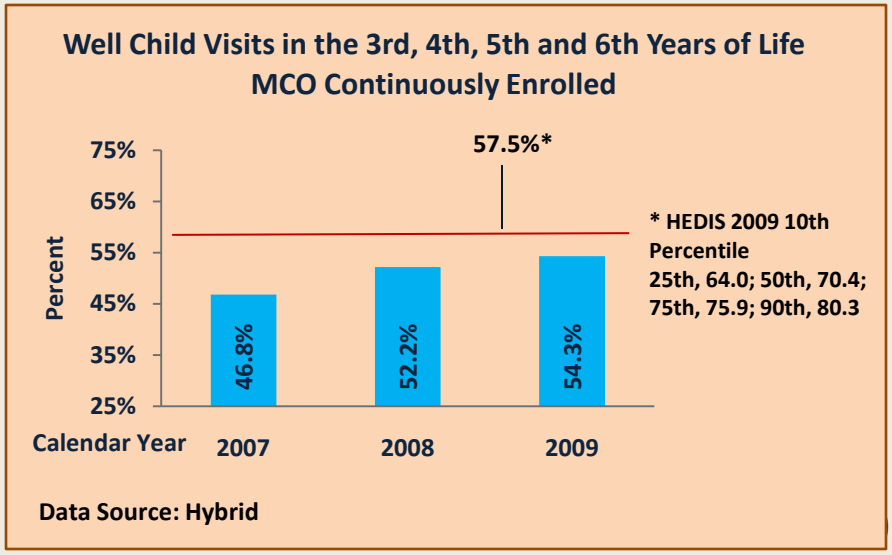




WELL CHILD VISITS: 3,4,5 & 6







DENTAL: Ages 3 Through 20

EPSDT Participation Rates Any Dental (CMS 416)	
Illinois FFY 2008:	45%
Illinois FFY 2005:	39%
National FFY 2008:	44%
Other states FFY 2008:	
Florida	26%
Pennsylvania	32%
California	35%
Michigan	39%
New York	40%
Ohio	43%
Texas	56%

Future Directions: Discussion

BYLAWS

Amended and Adopted September 16, 2005

ARTICLE I - NAME AND MANDATE

SECTION I

The Medicaid Advisory Committee (MAC) is created to advise the Department of Healthcare and Family Services (HFS), State of Illinois, about health and medical care services under the Medical Assistance Program pursuant to the requirements of 42 CFR 431.12 with respect to policy and planning involved in the provision of Medical Assistance.

SECTION II

The MAC shall have the opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program pursuant to 42 CFR Section 431.12(e).

ARTICLE II - MEMBERSHIP

SECTION I

The MAC shall consist of up to fifteen (15) voting members at least five (5) of whom must represent consumers of medical care. (A consumer is defined as a person who is not a health care provider.) All appointments of members shall be made in writing by the Director of HFS. These members shall include representatives of consumers' groups, including Medicaid clients, physicians (at least one of whom shall be Board Certified), and other representatives of health professions who are familiar with the health care needs, services, and resources available for low income population groups.

In addition, the Directors of the Department of Public Health, the Department of Children and Family Services, and the Secretary of the Department of Human Services or their designees shall be ex-officio members.

SECTION II

Terms of members shall be staggered. Each member shall serve for a term of two (2) years, or until a successor is appointed in writing by the Director of HFS. No member other than a consumer who is a Medicaid client may serve for more than two (2) consecutive terms. Upon two (2) years of nonmembership, a former member shall be eligible for reappointment. After two (2) consecutive terms, the term of a consumer member who is a Medicaid client may be extended at the request of the Chair and at the discretion of the Director of HFS.

SECTION III

Members of the MAC and duly appointed members of its committees and task forces shall serve without compensation, except that they may be reimbursed for allowable travel and other approved, necessary expenses in connection with the MAC meetings and business. Such reimbursement shall be consistent with the statutory provisions and with the regulations of the State of Illinois. Operating expenses of the MAC shall be borne by HFS.

SECTION IV

If a member misses three (3) consecutive regularly scheduled meetings in one year, his/her membership may be terminated at the discretion of the Director. A member may send a substitute who shall count as attendance by the member, and the substitute shall be able to vote at the discretion of the Chair.

ARTICLE III - OFFICERS

SECTION I

Officers of the Medicaid Advisory Committee shall consist of a Chair and Vice-Chair who shall be elected by the MAC from among its members.

SECTION II

The Chair and Vice-Chair shall be selected in the following manner: MAC members shall appoint a nominating committee annually. At the last meeting of the calender year, the nominating committee shall present a slate of candidates for the offices of Chair and Vice-Chair. Names and biographies of those nominated shall be mailed to members at least ten (10) days prior to the election. Nominations from the floor will be permitted. The officers will be elected by a simple majority of those present and voting at the first quarterly meeting in the following calendar year. An officer shall serve until his/her successor is elected.

SECTION III

Any officer of the MAC shall not be eligible to serve for more than two (2) consecutive years in the same office. The two-year membership term of any member serving in the capacity of Chair or Vice-Chair may be extended by the number of years served as Chair or Vice-Chair.

SECTION IV

The Chair of the MAC shall perform the duties ordinarily ascribed to such office and shall preside at all meetings of the MAC.

SECTION V

In the event of the Chair's absence, the Vice-Chair shall preside. If both are absent, the Administrator of the Division of Medical Programs or his/her designee shall serve in this capacity.

ARTICLE IV – MEETINGS

SECTION I

Regular meetings of the MAC shall be held at least quarterly, unless suspended by action of the MAC and are subject to the Open Meetings Act (P.A. 82-387). Such meetings shall take place at locations, dates and times agreed to by MAC membership.

It shall be the responsibility of HFS to give notices of the location, date and time of said regular meetings to each member of the MAC at least ten (10) days prior to each of the said meetings.

SECTION II

Special meetings of the MAC may be called provided that they are in compliance with the State's Open Meeting Act (P.A. 82-387).

SECTION III

An agenda of business scheduled for deliberation shall be prepared and distributed to the members of the MAC at least ten (10) days prior to a scheduled meeting of the MAC.

SECTION IV

A quorum shall be six (6) members.

SECTION V

Participation in MAC meetings shall be limited to MAC members and persons who have been invited by HFS and/or Chair to provide information on an agenda item. Participation by observers shall be at the discretion of the Chair. The Chair of the MAC has the right to limit the length of each observer's address to conform to the MAC agenda. All deliberations of the MAC and its committees shall be governed by Robert's Rules of Order to the extent not inconsistent with these Bylaws.

SECTION VI

Any member may add any topic to the agenda for action at the next meeting if it is submitted to HFS prior to the date the agenda for that meeting is mailed to the members. Upon the affirmative vote of a majority of the members present, however, an item can be added to the agenda and be

acted upon at the same meeting. Without a majority vote, action on new business will be taken at a future meeting.

ARTICLE V - COMMITTEES

SECTION I

The MAC is authorized to create subcommittees and workgroups as it deems appropriate.

SECTION II

The Chair and members of subcommittees and work groups shall be appointed by the Chair of the MAC in consultation with HFS. Subcommittee and work group membership may include persons who are not members of the MAC. Each subcommittee must have a MAC member serve on the subcommittee and represent the subcommittee at MAC meetings. HFS shall assign staff to provide support to the subcommittee and work groups.

SECTION III

At the second meeting of every year, the MAC will review the charge and membership of each subcommittee.

ARTICLE VI - PROFESSIONAL STAFF

SECTION I

The Administrator or his/her designee shall serve as the MAC official consultant. The Administrator may designate members of staff to assist in such consultation.

ARTICLE VII – AMENDMENT

SECTION I

The Bylaws may be amended by a simple majority of the members present at any regular or special meeting of the MAC if the proposed amendment is given in writing at least ten (10) days before said meeting.