ILLINOIS DEPARTMENT OF Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

MEMORANDUM

DATE: March 8, 2006

TO: Members of the Medicaid Advisory Committee

FROM: Anne Marie Murphy, Ph.D.
Administrator, Division of Medical Programs

RE: Medicaid Advisory Committee (MAC) Meeting

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The next meeting of the Medicaid Advisory Committee is scheduled for March 17, 2006. The meeting will be held via videoconference from 10 a.m. to 1 p.m. Those attending in Springfield will meet at 201 South Grand Avenue East, 3rd floor Videoconference Room B. Those attending in Chicago will meet at 401 South Clinton, 7th floor Videoconference Room.

The following meeting material has been posted to the department's Web site: The agenda for the March 17, 2006 meeting, the draft minutes from the January 20, 2006 meeting and the approved minutes from the November 18, 2005 meeting.

The current meeting material has been sent to the committee members electronically. Interested parties can access the meeting information by going to: http://www.hfs.illinois.gov/mac/ or http://www.hfs.illinois.gov/mac/news/index.html

In order to receive information on future MAC meetings, you will need to register to receive e-mail notification when information is posted to the MAC Web page. To register to receive the MAC e-mail notifications go to: http://www.hfs.illinois.gov/mac/notify.html

If you have any questions, or need to be reached during the meeting, please call 312-793-4706 in Chicago or 217-782-2570 in Springfield.

MEDICAID ADVISORY COMMITTEE

401 S. Clinton, 7th Floor Video-conference Room
Chicago, Illinois
and
201 South Grand Avenue East
3rd Floor Videoconference Room
Springfield, Illinois

March 17, 2006
10 a.m. - 1 p.m.

AGENDA

I. Call to Order

II. Introductions

III. Review of January 20, 2006 Meeting Minutes

IV. Administrator's Report
- All Kids Program Update
- DM and PCCM Update
- Legislative Session

V. Old Business
- KidCare/FamilyCare Update
- Medicare Part D Update

VI. New Business

VII. Subcommittee Reports
- Long Term Care (LTC) Subcommittee
- Dental Policy Review (DPR) Committee
- Public Education Subcommittee
- Pharmacy Subcommittee

VIII. Adjournment

Illinois Department of Public Aid
Medicaid Advisory Committee

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

January 20, 2006

Members Present
Eli Pick, Chairman
Laura Leon for Robin Gabel, IMCHC
Susan Hayes Gordon
Diane Coleman, PCIL
Debra Kinsey, DCFS
Kim Mitroka – Christopher Rural Health
Ralph Schubert, DPH
Neil Winston, M.D.

Members Absent
Pedro A. Poma, M..D.
Richard Perry, D.D.S
Robert Anselmo, R.Ph.
Alvin Holley
Nancy Crossman, DHS

HFS Staff
James Parker
Jacquetta Ellinger
Kelly Carter
Stephen Saunders, M.D.
Vicki Mote
Melissa Pop
Aundrea Hendricks
James Monk

Interested Parties
Tina Hartman, Healthpoint
George Hovanec
Kenzy Vandebroek, CDPH
Cher Beilfuss, Allergan
Ken Ryan, ISMS
Phyllis J Handelman, Handelman Consulting
Gerri Clark, DSCC
Lisa Gregory, IPHCA

Medicaid Advisory Committee (MAC)
Draft Meeting Minutes

January 20, 2006

I. Call to Order

Chairman Eli Pick called the meeting to order at 10:15 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

Ethics packets
John Larsen from the Office of the General Counsel advised that 5 MAC members had not yet provided the annual Ethics statement. Follow up was discussed for each packet needed.

III. Review of the Minutes

September minutes were reviewed. Diane Coleman requested that her name be added to the list of attendees, as she was present at the last meeting. Susan Hayes Gordon moved to approve the minutes and Laura Leon seconded the motion. The motion was approved.

IV. Administrator's Report

Jackie Ellinger, Deputy Administrator for Policy Coordination, lead the report on behalf of Dr. Anne Marie Murphy. Ms. Ellinger stated that the three primary areas to report were: 1) Disease Management (DM) and Primary Care Case Management (PCCM); 2) *All Kids*; and 3) Medicare Part D. The report on Medicare Part D will be given under the "Old Business" agenda item.

Medical Advisor, Dr. Stephen Saunders, Contract Management Bureau Chief, Kelly Carter and Deputy Director for Operations, James Parker would assist in the administrative report. Ms. Ellinger added that there were no updates to report for the Springfield legislative session or the Hurricane Katrina relief efforts.

1) Disease Management (DM) and Primary Care Case Management (PCCM)
Dr. Saunders reported on the planning for the DM case management implementation. He stated that the Request for Proposal (RFP) went out on 12/23/05. A bidder's conference was held on 01/10/06. Responses are due back by 2/7/06.

There are 3 target populations for disease management coverage.

1) Disabled adults that are not dual-eligibles. This group may be institutional or community based and number over 100,000 persons. This population is expensive for the state.

2) Individuals with "persistent asthma" as defined by HEDIS and drawn from the family health population, e.g., children under 19 and their parents or caretakers representing about 48,000 persons. The State will ask the vendor to develop a cost survey for this subset.

3) Frequent ER (emergency room) users defined as 6 or more visits to the ER in a non-emergency situation. From the approximate 1.4 million persons in the family health population, there are about 15 to 16 thousand inappropriate ER visits. HFS wants the vendor to reduce the future number of inappropriate visits and provide a return on investment. The agreement is risk based with the vendor guaranteeing a minimum cost savings at 50%.

The disease management process includes identifying persons, completing a risk assessment and developing a care plan. Claims data will be available to the vendor. A nurse should complete care plans. The vendor is expected to: 1) work with the client or family member to better self-manage care; 2) work with medical providers to encourage appropriate treatment; and 3) share data and feedback to the doctors providing medical management, developing standards and reporting back on outcomes.

- Diane Coleman recommended that the department encourage vendors to look at and work with the peer support model used by Centers for Independent Living (CILs) in respect to the disabled participants not in the Medicare group.

Ms. Ellinger noted HFS was using peer mentors in a project designed to help persons with disabilities work.

- Ms. Hayes Gordon asked if the goal of PCCM and DM is saving $45 million.

Dr. Saunders advised that the primary goal is to create better quality of care. James Parker stated it is correct that department expects to realize savings but the amount is $57 million. The department expects net savings of 2/3 from disease management and 1/3 from PCCM. There is an expectation that the PCCM and DM vendors will work together, sharing information on who is the Primary Care Physician (PCP).

PCCM is a variation of managed care. Enrollees will include parents, children and disabled adults who are not institutionalized. Persons with Medicare will not be included. Person will choose their PCCM or be auto-assigned. The PCCM

will provide a "medical home" with "24 –7" coverage. The PCCM will authorize hospital admission and specialty care.

The vendor must recruit an adequate number of providers. The vendor will recruit additional specialists including both pediatric and adult doctors. The vendor must take into account that the providers may choose patients and set a limit on the number of patients they will service. FQHCs. RHCs and health departments that meet the requirements may be PCPs.

- Ralph Schubert asked how the department sees other providers such as school-based clinics (SBC) fitting into PCCM.

Dr Saunders stated that direct access services could be used without referral. This would apply to SBC and health departments

- Ms. Hayes Gordon asked if the Division of Specialized Care for Children (DSCC) will have a role with foster children or children receiving Supplemental Security Income (SSI).

Dr Saunders stated that children in foster care or receiving SSI are not included in PCCM as their inclusion would require a federal waiver. These children have direct access to services and will not be assigned to a PCP. Other special needs children would be included. The department is looking at the possibility of specialists working as the PCP.

- Chairman Pick asked if the department envisioned a PCCM model that strengthens the patient–physician relationship by encouraging persons to choose a medical home already used.

- He asked if the department intended to create a new network. He pointed out that it is easier for a provider to work within an existing practice that includes a subset of Medicaid patients rather than establishing a new network or model.

Mr. Parker stated that the intent is to maintain existing patient-physician relationship, however, the department does not envision coming in with a new network. The goal is for more doctors to accept Medicaid patients and agree to sign a PCP agreement.

Ms. Ellinger added that PCCM will serve adults and children including some Aid to Aged, Blind and Disabled (AABD) adults.

Chairman Pick saw part of the challenge as looking at the market that includes a good number of doctors that are not seeking out new patients with Medicaid but have patients that have changed insurance from commercial to Medicaid.

He stated his experience is that if assignments are more burdensome, then specialists will leave. There are issues of low reimbursement and administrative

hassles. There is a cost factor of completing administrative tasks. The key to success is maintaining the relationship between doctors and patients.

Mr. Parker stated that we are swapping one network for another – starting with Medicaid and then hoping to expand. The vendor will have several contacts with patients to make a choice and not be defaulted. The goal for the PCCM administrator is to come up with a user-friendly system.

The department is putting together a list of provider requirements and will share these with the MAC.

- George Hovanec asked if there is a future plan to do a waiver request to expand the covered population?

Mr. Parker clarified that any recipients who may be enrolled in managed care without requesting a federal waiver will be included in PCCM. There is no plan to seek a waiver to include more recipients under PCCM at this time. Ms. Ellinger stated that HFS may seek a waiver or state Medicaid or SCHIP plan amendments to obtain federal funding for persons made eligible with *All Kids* expanded eligibility. This is unrelated to managed care.

2) *All Kids*

Ms. Ellinger provided an overview and update of the new *All Kids* expansion to provide health benefits to uninsured children of any income level. Starting July 1, 2006, Illinois will cover all children who have been without insurance since January 1, 2006. There are some exceptions like providing coverage if parents lost job and health insurance, covering newborns and covering children in families that earned too much to stay in one of the current plans for children. All KidCare plans will be renamed to *All Kids* over the next few months.

The state wants as many children as possible to be enrolled effective July 1, 2006. For that reason, a pre-registration process has been developed. There is lots of community involvement in pre-registration. The pre-registration form is now available on-line in English and Spanish.

HFS issued an alert to KidCare Application Agents (KCAAs) renaming them *All Kids* Application Agents (AKAAs) and explaining how they could assist in the pre-registration process.

- What expectation is there that employers will shift their employee insurance to *All Kids*?

All Kids requires a significant period of not being insured to discourage employers and employees from dropping existing employer sponsored coverage.

- Does the on line pre-registration form allow the AKAA to be identified?

There is no place for the AKAA to be identified on the on line pre-registration form. AKAAs should assist families to pre-register on paper applications forms if the AKAA wishes to assist the family with the *All Kids* application when it is available.

- When a person with an existing case makes an *All Kids* application, must they go to the local DHS office?

Persons with existing cases wishing to add another family member need to contact their caseworker. The system is the same as today. The request to add a person goes to the place maintaining the case file.

- Will children in households with income over 200% FPL be excluded from the PCCM model?

Ms. Ellinger clarified that PCCM would be the model for services for most children, not just newly eligible children, as well as adults except for groups of persons who may not be mandated to enroll in managed care without a federal waiver.

- Ken Ryan asked if copays made in addition to Medicaid rates would be deducted? If yes, he recommends that the state reconsider this policy, as it is important in attracting physicians.

- Ms. Hayes Gordon reiterated Mr. Ryan's observation that copays deducted against the Medicaid rate is not a good idea.

Mr. Parker stated that the copay would be deducted from the Medicaid rate. He added that we could look at not deducting copays for certain services. Mr. Parker noted that there is a commitment for a 30-day payment cycle for physicians providing services to children.

Ms. Ellinger added that the department is not changing eligibility rules for currently eligible families. That is, eligibility criteria for families with income at or below 200 percent of poverty will not change with the exception that children will not have to meet immigration status requirements.

- Ralph Schubert asked whom school based clinics should talk to about the pre-registration process?

Ms. Ellinger suggested he call Gretchen Grieser who is heading up *All Kids* outreach for HFS.

Laura Leon added that March is awareness month for school based clinics and that the Illinois Coalition for School Based Clinics is working to ensure that correct information is available.

Ms. Ellinger reported that the department has selected GMMB to handle *All Kids* marketing. The marketing firm has done a lot of work with Covering Kids nationally and will be partnering with the Illinois Maternal and Child Health Coalition (IMCHC) to work on *All Kids*.

Diane Coleman advised that the Progress Center has a one-hour radio program serving all ages in the Latino community. This is a possible venue to reach families about *All Kids*. Ms. Ellinger promised to have someone follow-up on this offer.

V. Old Business

Medicare Part D. Mr. Parker stated that there has been a significant amount of confusion with the initial implementation. The good news is that implementation has been OK for the largest percentage of enrollees. HFS shifted coverage for about a half million persons and only five percent had problems. This is a small percentage but the number with problems is significant given that the overall population is so large.

There were two problems for the dual-eligibles. Some persons didn't know which Prescription Drug Plan (PDP) they were enrolled with and the systems that were set up to assist with this did not work well. HFS is working through these problems on a case-by-case basis. This has been time consuming.

A second problem for dual eligibles was that enrollment was switched in the system but the indicator that showed they were enrolled for the Low Income Subsidy did not follow. As a result, co-pays were much higher than appropriate. When no other solution developed, HFS established a process to allow recoding its database so the state could process pharmacy payments for these clients. Pharmacies were notified of this policy via direct contact or the Web site.

For the Circuit Breaker/SeniorCare group there were some of the same problems and we were able to recode showing no Medicare prior to January 1. There was a lot of confusion, so pharmacy education to allow Medicare billing was needed. We worked with PacifiCare to have an operational system.

The federal rules state that every patient has a right to a "transitional script" after January 1. There have been significant problems in implementation. It has been difficult for pharmacies to get paid at the regular copay. So patients saw very high, not regular, copays. We are working with the PDPs to honor the transition process fully.

HFS has redeployed staff to increase the number of people available to answer the hotline and assist clients. HFS has yet to see a significant decrease in problem cases but this may lighten up in the next week allowing better response times on the phones. On whole, pharmacies have been extremely cooperative. This is also true for the corporate headquarters of the pharmacy chains.

Ms. Coleman states that she is working with the Make Medicare Work coalition and believes that the department has done a wonderful job and was sixth in the nation to do a fix for those unable to get the prescriptions filled.

Kenzy Vandebroek added that the Chicago Department of Public Health (CDPH) is also happy that HFS did what it could to better serve clients.

KidCare/FamilyCare. Vicki Mote, Chief of the Bureau of KidCare, provided the committee with an update on the KidCare/FamilyCare program. She stated that the KidCare Unit has spent a lot of time enrolling parents going from 133% to 185% FPL under the new FamilyCare standard. Next meeting she can report the increase in the number of covered parents.

There are about 2,000 pending applications. Complete applications are currently processed within 11 days. Enrollment data is provided for period as of November 30, 2005.

The web-based interactive application was implemented statewide on August 11. Since then, KidCare has received 10,530 web applications: 6,540 from the general public and 4,080 from KCAAs.

VI. New Business

1) Ms. Ellinger reported that Congress has agreed upon language for the budget reconciliation. The legislation is expected to be enacted shortly. It includes dramatic changes for the Medicaid program including Long Term Care asset rules and other changes effecting Medicaid reimbursement.

Among the most alarming changes is that, beginning July 1, 2006, states may no longer accept that a person is a citizen based on their declaration of citizenship. All persons will have to provide documentation of citizenship. At redetermination current eligible citizens will have to document their citizenship. Ms. Ellinger expressed concern that many seniors may be unable to provide information even though they are citizens.

There is no evidence that persons misrepresent themselves as citizens when they are not citizens. The effect of this policy change could be shifting a huge cost back on the state or the loss of benefits by many persons who cannot document that they are citizens. This will have a large impact on the provider community for payment for services especially nursing facility and other long-term care.

2) Ms. Ellinger stated that the department is looking at replacing the monthly Mediplan card with an annual medical card.

The annual card would be only an I.D. card, so providers would need to use one of the available systems to verify eligibility. There may be one card issued for each individual showing his or her name, birth date and RIN. The back of the card would include a telephone numbers for members and providers.

The annual card would be reissued not at redetermination but by zip code area. Persons could call for a replacement card and new cards would be issued for new individuals.

There was discussion on the increased burden on providers. Chairman Pick pointed out that the burden is no different than found with other health plans.

3) Chairman Pick stated that he had seen a copy of a notice for an RFP for non-emergency transportation under a single vendor. He had concern about the reliability and access if there is only a single vendor statewide.

Kelly Carter, Chief of the Bureau of Contract Management, stated that three bids had been received thus far. She advised that the experience in other states with a single vendor increased access. Initially other states got complaints from transportation providers, not medical providers. The RFP requires the vendor to provide access to all parts of the state. The vendor is expected to subcontract with a pool of existing transportation vendors working with the department. The result will be a provider network and not a single entity providing service.

Chairman Pick expressed concern about the reliability of the vendors showing up timely for pick up both before and after for appointments.

Ms. Carter started that there will be access standards and vehicle requirements. HFS working with the vendor can use the best providers and eliminate poor quality providers.

The plan is for July 1 implementation. It will be possible to enroll a private auto as a provider type.

VII. Subcommittee Reports

Long-Term Care (LTC). Eli Pick reported that the committee had met in December and discussed the Conference on Aging. Also discussed were 44 additional awards for Supportive Living Facilities (SLF). There are currently 26 existing SLF, including one for blind individuals. The committee did incorporate to allow for special needs individuals, including mental health.

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

Chair Eli Pick adjourned the meeting at 12:02 p.m. The next MAC meeting is scheduled for March 17, 2006.

Medicaid Advisory Committee
January 20, 2006
KidCare/FamilyCare Report

Enrollment

- We have around 2,000 pending applications in the KidCare Unit. We are processing clean applications at 11 days.

- Enrollment data is attached. Enrollment data as of 11/30/05:

  a. 1,060,718 pre-expansion children (up to 100% of FPL)
  b. 354,164 pre-expansion parents (up to approx. 35% of FPL)
  c. 6,205 Moms and babies expansion (133% to 200% of FPL)
  d. 73,620 Phase I (100% to 133%) and 38,375 Phase II expansions (133% - 185% of FPL)
  e. 4,584 Phase III (over 185% - 200% of FPL)
  f. 30,788 FamilyCare Phase I (38% - 49% of FPL)
  g. 31,427 FamilyCare Phase II (49% - 90% of FPL)
  h. 47,656 FamilyCare Phase III (90% to 133% of FPL

FamilyCare Expansion

We expanded FamilyCare to 185% of poverty January 1, 2006.

Web-based application capability

We implemented our web-based application statewide on August 11. Since then, we have received a total 10,530 web apps: 6,450 from the general public and 4,080 from KCAA's.

MAC 11/18/05

	5/31/2005		6/30/2005		7/31/2005		8/31/2005		9/30/2005		10/31/2005	11/30/2005
	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Current 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	1,060,718
KidCare Phase I	66,490	66,499	67,647	67,669	68,804	68,904	69,825	70,158	70,569	71,155	72,522	73,620
KidCare Phase II	38,085	38,088	38,340	38,344	38,607	38,612	38,210	38,196	37,903	37,865	38,184	38,375
KidCare Phase III	3,531	3,531	3,710	3,710	3,865	3,864	3,991	3,984	4,179	4,176	4,342	4,584
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	6,205
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	354,164
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	30,788
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	31,427
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	47,656
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**	**1,647,537**

Illinois Department of Public Aid
Medicaid Advisory Committee

401 S. Clinton Street, Chicago, IL
210 S. Grand Avenue East, Springfield, IL

November 18, 2005

Members Present
Eli Pick, Chairman
Laura Leon for Robin Gabel, IMCHC
Jill Fraggos for Susan Hayes Gordon
Richard Perry, D.D.S
Robert Anselmo, R.Ph
Debra Kinsey, DCFS
Alvin Holley
Nancy Crossman, DHS
Diane Coleman, PCIL

Members Absent
Pedro A. Poma, M.D.
Kim Mitroka – Christopher Rural Health
Neil Winston

HFS Staff
Anne Marie Murphy, Ph.D.
Jacquetta Ellinger
Deborah Watkins
Carla Lawson
John Larson
Aundrea Hendricks
James Monk

Interested Parties
Cher Beilfuss, Allergan
Chuck Sauer, NPHA
Robin Scott, CDPH
Mark Mlynarczyk, MedImmune
Cheryl Luria - Amylin
Deb Mathews for Gerri Clark, DSCC
Lisa Gregory, IPHA

Medicaid Advisory Committee (MAC)
Draft Meeting Minutes

November 18, 2005

I Call to Order

Chairman Eli Pick called the meeting to order at 10:15 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

Ethics packets. John Larsen from the Office of the General Counsel advised that 5 MAC members had not yet provided the annual Ethics statement. Follow-up was discussed for each packet needed.

III. Review of the Minutes

September minutes were reviewed. Robert Anselmo requested a correction on page 3 regarding his statement about DEA to read as follow: " Mr. Anselmo stated the DEA has relaxed the rules for controlled substances. Pharmacists can give a 30-day supply of a 3C-5 and 7 day supply of a C-2." No other corrections. Richard Perry moved to approve the minutes and Robert Anselmo seconded the motion. The motion was approved.

IV Administrator's Report

Dr. Anne Marie Murphy and Jackie Ellinger provided an update on the hurricane Katrina relief efforts, the new All Kids program and the role of the MAC.

1) Regarding the hurricane Katrina relief effort, Illinois has enrolled 4,100 persons identified as disaster evacuees, mostly from Louisiana, with Medicaid billing for 400 persons. The way that the federal CMS will finance payment has not been resolved.

CMS has proposed contributing the state's share of the federal match. The state of Louisiana would cover 30 percent and the feds would cover 70 percent. Dr. Murphy added that Louisiana's service package is more limited than Illinois.

Illinois revised application procedure for hurricane victims by assuming Illinois residency and by temporarily waiving some verification requirements such as citizenship, disability and income.

HFS is trying to coordinate with the Department of Human Services (DHS) on cash and food stamp benefits. This is difficult as rules and time frames are

different from program to program. For example, Food and Nutrition Service (FNS) says states can't enroll after October 1, while the federal CMS allows enrollment through January 1.

Ms. Ellinger stated that questions from the Metropolitan Chicago Healthcare Council (MCHC) helped us think through our relief effort response. The work of DHS was also recognized as most valuable.

2) Dr. Anne Marie Murphy reported that the All Kids legislation passed quickly reflecting the strong support for this initiative. She stated that now the work begins on implementation. HFS is working on a mechanism to identify persons who are potentially eligible. We will reach out to three groups: children eligible now under the current KidCare policy (estimated as one half of the uninsured population); non-citizen children and; children meeting the current citizenship rules but newly eligible for All Kids.

Dr. Murphy shared some of the outreach strategy planning. There is a card being developed for persons interested but not yet eligible. There is a screening tool to determine if children may be eligible now. A pre-registration system is also being developed. The department is also writing a request for proposal (RFP) for marketing and outreach. Information will be available through the Governor's office.

One eligibility requirement under All Kids is that a child has to be uninsured for 6 months prior to the time of initial registration for July 1. There will be some exceptions that include: loss of insurance due to loss of employment; families with a newborn child; or children whose eligibility for KidCare had been cancelled due to increased income within the last 12 months.

We have developed an All Kids Web site and are in the process of adding an All Kids phone number.

Dr. Murphy stated that Ms. Ellinger would be involved in writing the All Kids rules for eligibility. Decisions need to be made regarding when premiums are due and what happens if premiums are not paid.

Dr. Murphy stated that the department is looking at going with permanent medical assistance cards. This means providers would have to do an eligibility look-up to determine if a child is currently eligible. Also, providers won't be able to make assumptions about different income levels if the medical assistance cards look alike.

Ms. Ellinger pointed out that the All Kids statute doesn't specifically set cost sharing amounts so that cost structure must be clearly established. Dr. Murphy added that we want ease in understanding the cost structure. We could go with

cost as a percentage or as a flat fee. We must grapple with our system and be ready for July 1.

We will also need to develop our Primary Care Case Management (PCCM) and disease management models. Dr. Murphy advised that we are looking at the 27 to 29 states that have PCCM. We plan to use a medical home model with patient assignment to physicians. We will issue an RFP for one or more vendors to assist us with medical case management.

Dr. Murphy encouraged interested parties to raise questions, concerns or desires for the new system. She gave the example of the role of school based clinics. Can they be a PCP? Will the school be open long enough to meet the persons needs? Is the clinic accessible? Can we allow for self-referral to another PCP?

Dr. Murphy continued that we will grapple with the most appropriate way to ensure access to the primary care physician. For example, what if a person decides to go to another provider because they do not want their chosen PCP to know about a health condition, e.g., STD.

She stated that balancing care in a holistic manner with a person's need for access must be considered. In the mental health area, we need to look at patients going to multiple providers to get prescriptions. This may not be the best for coordination of care.

3) Participants were provided with a copy of the amendment to House Bill 806 (All Kids). Dr. Murphy stated that the role of the MAC is important to the success of All Kids and stated that she is interested in recommendations of persons to participate. She directed the group to section 50, which states that the department shall present details regarding implementation of the program to the MAC and the MAC shall serve as the forum for healthcare providers, advocates, consumers and other interested parties to advise the department with respect to the program.

Ms. Ellinger stated that it is hard to get the participation of consumers or consumer advocates, defined as not paid for services. She encouraged participants to recommend anyone that might be able to serve.

Participants were provided a copy of an amendment made by Senator Durbin recommending that the U.S. Senate not extend the capital gains and dividend tax cuts but use the funds generated to further the goal of ensuring that children have access to health insurance coverage.

Jill Fraggos commended HFS on work done so far and indicated that Children's Memorial Hospital staff are interested in working with the department as it moves to implement All Kids.

Dr. Murphy advised that she is working with HFS medical advisor Dr. Stephen Saunders' workgroup on physician-oriented issues.

Dr. Perry asked if all medical services would be covered under All Kids. Dr. Murphy advised that all services except non-emergency transportation and waiver services would be covered.

Dr. Murphy stated that there are advantages for doctors to participate in All Kids. A key advantage is payment on a 30-day payment cycle. Another advantage is that doctors, like dentists, may tag patients and be promised a certain caseload. This allows the doctor to see specific patients or have only a specific number of patients.

Dr. Murphy shared that physician enrollment has increased by about 1,500.

HFS is looking at disease management models like "Bend the Trend", to find the best option for Illinois. We are looking at ER management with appropriate referrals to community services such as mental health.

Dr. Murphy advised that RFPs would be issued. She emphasized that HFS would focus on health care models that are patient friendly. She and HFS Director Barry Maram would be happy to meet with vendors to hear presentations on topics related to the All Kids implementation. However, no information regarding the RFP could be shared due to the strict procurement rules.

Laura Leon noted that marketing should be linked with enrollment and that an effective marketing strategy includes "putting a face" on All Kids.

Dr. Murphy agreed with her observation and added that it is easy to do commercials but we also want to link the media campaign with sign-ups. She added that different entities have special skills – some are good with marketing while some are better at reaching out.

V. Old Business

KidCare/FamilyCare. Deborah Watkins, KidCare Central Unit (KCU) manager, provided an update on the KidCare/FamilyCare program. There are about 3,000 pending applications. Complete applications are currently processed within 12 days.

The FamilyCare income standard will be expanded to 185 percent of the federal poverty level effective January 1, 2006. A mailing went to all active Share/Premium /Rebate families in October informing them of the expansion. A request to add parents was enclosed. As of November 14th, almost 2,000 requests to add over 2,700 parents had been received. KidCare began enrolling parents at intake on November 16th effective for January 1, 2006 coverage.

The web-based interactive application was implemented statewide on August 11, 2005. Since then, KidCare has received 5,728 web applications: 3,748 from the general public and 1,980 from KCAAs. The department is offering training and technical support to KCAAs to encourage usage of the application.

It was noted that the November report handout was not included but will be added to the packet for the next MAC meeting.

Medicare Part D. Ms. Ellinger reported that HFS is getting the message out, in part, through the Public Education Workgroup. The message is two-part: Part 1 on dual-eligibles and; Part 2 is for current enrollees in SeniorCare.

Dual-eligibles are getting information through the Illinois Health Benefits Hotline and were sent a latter in September. The letter didn't distinguish between dual-eligible and disability participants. Persons with Medicare and in one of the special medical groups, e.g., QMB, SLIB or QI-1 also received a letter in September directing them to enroll for Medicare Part D with 2 telephone numbers to call – the Senior Helpline and Senior Health Insurance Program.

All persons receiving medical benefits under the Aged, Blind and Disabled programs, except nursing home residents, will receive an insert reminder with their November and December medical cards. The reminder tells clients that starting January 1, 2006, Medicare will pay for prescription drugs and encourages clients to choose and join a Medicare prescription drug plan.

The department has shared enrollment information with education workgroups and advocates. We may need to communicate more with pharmacists to ensure that information provided to clients is consistent.

The Illinois Cares Rx caravan continues to tour the state to talk about Medicare, SeniorCare, Circuit Breaker and Medicaid. We hear the stories of confusion for participants. We will continue to explain the changes, but expect it will take a long time for clients to understand.

Illinois will have 15 stand alone prescription drug plans (PDPs) from 12 different companies that will not cost a person more than the average premium. Two stand alone plans will coordinate benefits with Illinois Cares Rx. These are PacifiCare Saver plan and AARP Medicare Rx of United HealthCare. A combination of Federal low-income subsidy coverage and Illinois Cares Rx will allow coverage similar to current SeniorCare and Circuit Breaker.

Dr. Murphy added that the Illinois Cares Rx plan will do a "full-wrap" coverage based on the PDP preferred drug list and the department would do a reconciliation of payment at the back end. She stated that we are trying to make the process as

simple as possible for the clients. Auto-assignment is being done for the SeniorCare and Circuit Breaker folks.

Ms. Ellinger stated that the federal CMS had made a mistake in Wisconsin and Illinois by auto-assigning SeniorCare clients to one of 12 plans rather than the 2 plans coordinated with Illinois Cares Rx. Ms. Ellinger stated that the department is trying to get the word out and to correct the PDP assignments.

Dr. Murphy added that there is a "silver lining" as the SeniorCare persons were also auto-enrolled for the federal "Extra Help".

Ms. Ellinger continued that from this point forward information would come from the PDP. There will be a welcome letter followed by a member card and membership handbook before January 1st.

Regarding long-term care residents, Ms. Ellinger stated that Medical Assistance cards are usually mailed together in one envelope for all Medicaid patients at a facility. The department is talking about sending a unique notice to the nursing home population to explain changes.

In response to a question from Robin Scott, Ms. Ellinger advised that the list of Illinois prescription drug plans is available at <www.medicare.gov>. There is a list of the freestanding plans operating in Illinois and a Medicare Advantage or HMO list organized by county within Illinois. Other resources with good information include <www.Illinoisbenefits.org>, Illinois SHIP and the Make Medicare Work website.

Dr. Murphy added that there are 4 Medicare Advantage (HMO) plans available in Illinois currently. These include OSF Health, HealthSpring, WellCare and Health Alliance. She added that Medicare Advantage enrollees have several options for coverage that include: 1) choosing to continue with prescription drug coverage via the Advantage plan and losing the Illinois Cares Rx wrap benefit 2) change to a coordinating Advantage plan and receive Illinois Cares Rx coordination benefits; or 3) change to fee-for-service Medicare coverage and choose a stand alone plan.

Robert Anselmo shared that the new Medicare Part D plan is an "absolute mess." The plan is horrid for pharmacies because of all the changes. He anticipates nothing but problems for the first month and a half of the program. He finds it frightening that a person will make a decision on December 31st and walk into a pharmacy requesting medications without a medical card on January 1st. Also, because of the Medicare Part D enrollment process this situation will happen every year after open enrollment. He stated that if a patient doesn't have a plan card the pharmacist must follow up by looking for eligibility via electronic claims systems.

Eli Pick asked what would happen if a patient needed the medication but was unable to prove Part D coverage and unable to pay. Chuck Sauer stated that hopefully most pharmacies would make a good faith effort and dispense initially without a card to accommodate the patient's need.

Dr. Murphy stated that Senator Durbin was sponsoring an amendment to allow Medicare beneficiaries to pick a pharmacy plan at a later time. Although states have advised against it, dual-eligibles will be transitioned to their PDP effective January 1st. Eli Pick responded that it would be a travesty if patients were unable to get their medications.

Ms. Ellinger stated that the issue is poor people choosing and not being covered quickly and this will be an ongoing problem. Dr. Murphy added that the Medicare Part D bill was written by Medicare not Medicaid staffers. This creates problems.

Eli Pick expressed concern for persons going in and out of long-term care facilities. He stated that currently about 20 percent of patients are in a facility on a short-term basis. If a person is lucky enough to be in a nursing home at the time of choice, the enrollment should be okay. However, persons "going in" or "coming out" of a nursing home must make additional choices. Mr. Pick noted that patients in long term care facilities on a short-term basis are the fastest growing segment of the nursing home population, growing at a rate of 2 percent per year.

VI. New Business

1) The MAC meeting dates for 2006 will be the 3rd Friday of every other month beginning in January. Specific dates will be provided.

2) Revisions in the MAC by-laws, changing reference from the Department of Public Aid to HFS, were reviewed. Chairman Pick asked for a motion to change the by-laws. Ralph Perry motioned and Robert Anselmo seconded the motion to change. The motion was passed unanimously.

VII. Subcommittee Reports

Long Term Care (LTC). Eli Pick reported that the subcommittee had met and discussed the upcoming White House Conference on Aging that is scheduled for December 11th. Illinois will be sending 34 representatives with Charles Johnson elected as chairman of the Illinois delegation. The next meeting is the Governor's Conference on Aging scheduled for December 8, 2005.

Dental Policy Review (DPR). Richard Perry provided the update. He reported that the subcommittee last met on November 2nd.

1) Currently there are 3 community dental service grants. These include: Village of Oak Park; Infant Welfare Society with full time staff on board for June 2005 through May 2007, and; Milestone Center in Rockford, a not for profit agency for developmentally disabled that is in the process of establishing a dental clinic. Dr. Perry noted that the University of Illinois dental school uses these sites for interns. In Saline County, there is a full time dental component in Harrisville.

2) The subcommittee has approved an office reference manual. Exceptions for the manual are being reviewed for final approval.

3) Increased fee reimbursement for specific preventative services has been approved for January 1st. The services include periodic oral exams, prophylaxis, fluoride treatment and sealants (one lifetime for molars).

4) HFS and Doral dental are conducting an outreach initiative for kids that haven't seen a dentist in a year.

5) A final update on the system to provide care in the period from March 2004 through September 2005. There were 2,000 providers and 1,600 claims submitted. Participation reported as:

- Oral surgeons 133 enrolled 93 claims
- Orthodontists 101 enrolled 66 claims
- Pediatric dentists 82 enrolled 61 claims

Dr. Perry stated that there is a need for better reimbursement. Payments cover only 20-25 percent of overhead. Only about 27 percent of the dentists in Illinois participate.

6) The next meeting of the Dental Policy Review Subcommittee is scheduled for March 1, 2006.

Public Education Subcommittee. The subcommittee has not met since the last MAC meeting.

Pharmacy Subcommittee Charge. Robert Anselmo stated that the subcommittee will select a date to meet but not before the end of the year.

VIII. Chair Eli Pick adjourned the meeting at 11:50 a.m. The next MAC meeting is scheduled for January 20, 2006.

Medicaid Advisory Committee
November 18, 2005
KidCare/FamilyCare Report

Enrollment

- We have around 3,000 pending applications in the KidCare Unit. We are processing clean applications at 12 days.

- Enrollment data is attached. Enrollment data as of 9/30/05:

  a. 1,058,172 pre-expansion children (up to 100% of FPL)
  b. 351,035 pre-expansion parents (up to approx. 38% of FPL)
  c. 6,133 Moms and babies expansion (133% to 200% of FPL)
  d. 70,569 Phase I (100% to 133%) and 37,903 Phase II expansions (133% - 185% of FPL)
  e. 4,179 Phase III (over 185% - 200% of FPL)
  f. 31,020 FamilyCare Phase I (38% - 49% of FPL)
  g. 31,840 FamilyCare Phase II (49% - 90% of FPL)
  h. 45,996 FamilyCare Phase III (90% to 133% of FPL

FamilyCare Expansion

We are expanding FamilyCare to 185% of poverty January 1, 2006. A mailing went to all active Share/Premium/Rebate families in October informing them of the expansion. A request to add the parents was enclosed. As of Monday, we had received almost 2,000 requests to add over 2,700 parents.

We started enrolling parents at intake yesterday effective January 1.

Web-based application capability

We implemented our web-based application statewide on August 11. Since then, we have received a total 5,728 web apps: 3,748 from the general public and 1,980 from KCAA's.

MAC 11/18/05

	3/31/2005		4/30/2005		5/31/2005		6/30/2005		7/31/2005		8/31/2005	9/30/2005
	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Current Numbers	Current Numbers
Pre-expansion children	1,038,707	1,038,889	1,044,607	1,044,986	1,044,733	1,046,355	1,045,187	1,049,594	1,043,331	1,050,518	1,056,358	1,058,172
KidCare Phase I	69,102	69,106	65,319	65,347	66,314	66,490	67,212	67,647	68,118	68,804	69,825	70,569
KidCare Phase II	35,692	35,702	37,553	37,564	38,088	38,085	38,373	38,340	38,668	38,607	38,210	37,903
KidCare Phase III	4,589	4,587	3,212	3,209	3,534	3,531	3,720	3,710	3,868	3,865	3,991	4,179
Moms and Babies Exp	6,481	6,483	6,134	6,143	6,153	6,180	6,147	6,234	6,065	6,218	6,206	6,133
Pre-expansion parents	346,297	346,453	348,011	348,256	348,792	349,762	347,019	349,586	345,825	350,119	351,359	351,035
FamilyCase Phase I	27,863	27,870	30,086	30,094	30,482	30,513	30,674	30,790	30,777	30,958	30,993	31,020
FamilyCare Phase II	29,593	29,594	30,554	30,563	30,823	30,887	30,926	31,131	30,815	31,166	31,581	31,840
FamilyCare Phase III	38,547	38,552	38,879	38,897	40,658	40,795	42,033	42,402	43,164	43,752	45,046	45,996
TOTAL	**1,596,871**	**1,597,236**	**1,604,355**	**1,605,059**	**1,609,577**	**1,612,598**	**1,611,291**	**1,619,434**	**1,610,631**	**1,624,007**	**1,633,569**	**1,636,847**