Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee - January 11, 2013

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

Members Present
Susan Hayes Gordon, Chairperson
Kathy Chan, IMCHC
Jan Grimes, IHHC
Judy King
Andrea Kovach, Shriver Center
Karen Moredock, DCFS
Eli Pick, Post Acute Innovations
Edward Pont, ICAAP
Renee Poole, IAFP
John Shlofrock, Barton Mgt.
Linda Shapiro, ACHN
Sue Vega, Alivio Medical Center

HFS Staff
James Parker
Arvind Goyal
Michael Koetting
Kelly Cunningham
Mercy Sanchez
Debra Clemons
Paul Bennett
Sally Becherer
Sherri Salada,
Sameena Aghi
Andrea Bennett
Jennifer Partlow
James Monk

Interested Parties
Frank Anselmo, CBHA of IL
Chris Beal, Otsuka
Victoria Bigelow, Access to Care
Libby Brunsvold, MedImmune
John Bullard, Amgen
Kimberly Call, Brogen Idec
Kelly Carter, IPHCA
Gerri Clark, DSCC
Laurie Cohen, Civic Federation
Mathew Collins, Health Spring
Mike Cotton, Meridian Health Plan
Mark Davis, Vertex Pharmaceuticals
Andrew Fairgrieve, HMA
Gary Fitzgerald, Harmony-Wellcare
Eric Foster, IADDA
Paul Frautz, Well Care
Dean Groth, Pfizer
Barbara Hay, FHN
Jeff Himmelberg, GSK
George Hovanec, Consultant
Teresa Hursey, Aetna

Members Absent
Mary Driscoll, DPH
Glendean Sisk, DHS

Interested Parties continued
Keith Kudla, FHN
Joel Kurzman, Nat. Assn of Chain Drug Stores
Michael Lafond, Abbott
Nadeen Israel, Heartland Alliance
Mary Kaneaster, Lilly
Margaret Kirkegaard, IHC, AHS
William Kolen, LAF
Terry McCurren, Orsuka
Kevin McFadden, Astra Zeneca
Susan Melczer, MCHC
Emily Miller, IARF
Phil Morts, Gilead
Gina Mooi, Humana
E. C. Muhammad, Circle Family Healthcare
Michael Murphy, Meridian
Sanjoy Musunuri, Aetna Better Health
Sergio Obregon, CPS
Phung Osborn, Baxter
John Peller, Aids Foundation
Melissa Picciola, Equip for Equality
Ena Pierce, HealthSpring
Dana Popish, BCBSIL
Jay Powell, Amerihealth Mercy
Frank Quintieri, Baxter
Mary Reis, DCFS
David Reynolds, Well Care
Sam Robinson, Canary Telehealth
Nancy Ronquillo, Children's Home & Aid Society
Phyllis Russell, ACMHAI
Ken Ryan, ISMS
Tina Sacks, IL Assn. of Free & Charitable Clinics
Amy Sagen, UI Hospital & HS system
Sam Smothers, MedImmune
Bernadine Stetz, Molina Healthcare
Johnathan Thombeni, Byram Healthcare
Katie Tuten, Catholic Charities
Erin Vaughn, Astra Zeneca
Deiny Velasquesz, ICIRR
Nicole Willing, Mylan

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I. Call to Order

Chairperson Susan Gordon called the meeting to order at 10:00 a.m.

II. Introductions

Attendees in Springfield and Chicago introduced themselves.

III. Approval of November 16, 2012 Meeting Minutes

Kathy Chan asked for a name correction on page 7 from Kelly Cunningham to Kelly Carter. With this change, the November minutes were approved.

IV. Old Business

MAC 2013 meetings

Dates are January 11, March 8, May 10, July 12, September 12 and November 7. These dates have been posted on the MAC web site.

Drug Utilization and Review (DUR) committee status and MAC motion

At the September MAC meeting, Dr. Judy King had made a motion that "the MAC recommends that HFS establish a DUR committee consistent with federal law and compliant with the Illinois Open Meetings Act". She stated that the HFS Drug and Therapeutics committee managed by the University of Illinois and the Illinois State Medical Society lacks transparency. At the meeting, Dr Pont made a motion to table Dr. King's motion until Mr. Parker reports back on how the DUR committee operates. James Parker, Deputy Director of Operations had made a report on the DUR committee at the November MAC meeting.

Mr. Parker continued his report at today's meeting. He provided a review on the operation of the DUR committee and transparency in the review process. HFS has the drugs and therapeutics (D & T) committee and the DUR committee. The two committees have different functions.

The D & T committee is a committee of the Illinois State Medical Society with members appointed by the medical society and services are provided free of charge. When new drugs come on the market they are first automatically on prior approval. HFS uses the D & T committee to review coverage decisions when new drugs come on the market and whether the drug should be controlled by prior approval because: the drug may be abused; the drug may have several warnings; it is designed for a narrow niche situation; or is extraordinarily expensive. In addition, HFS puts drugs on prior approval for various reasons and has a preferred drug list. In a particular class of drugs if the Department determines there are drugs that are therapeutically equivalent, it will choose the one with the lowest net cost. The D & T committee reviews those decisions from a clinical basis.

The DUR committee is staffed by physicians and pharmacists from the University of Illinois at Chicago with members appointed by HFS. The committee is responsible for reviewing drug utilization and looking for prescribing patterns they would cause them to recommend utilization controls. They may also reach out to doctors to educate them on prescribing issues they may see. To give MAC members a taste of what members of the DUR committee do as well as be more transparent, the HFS website has a list of drug utilization edits at http://www.hfs.illinois.gov/assets/duredits.pdf

HFS has also put on the website a series of drug utilization decision examples and will post some every month showing things like the types of decisions that are made on the four-script policy. They look like brief case studies. He reviewed an example of a 51 year old male with hypertension receiving duplicate therapy and the decision-making process made together with the provider to authorize only one of the drugs. In summary, Mr. Parker stated that HFS has established a DUR committee and it is complying with the Open Meetings Act (OMA) by posting meeting dates and agenda.

Chairperson Gordon stated that her understanding from HFS staff is that the DUR committee is required to follow the Open Meetings Act and federal guidelines. It therefore has to publish minutes and that all members of

the DUR committee have completed both the ethics and OMA training. The web page has been created and members can locate it under the Boards and Commissions section with the link to be shown in the minutes and at http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommisions/DUR/Pages/default.aspx . The minutes for the first two DUR meetings should be available by January 28. Any further questions concerns or motions can be addressed directly in their meeting.

At the Chair's request, Dr. King read her motion with supporting rationale. She stated that HFS has created the DUR committee and it appears it will be compliant with the Open Meetings Act. Members voted on Dr. King's motion as stated, recognizing that the Department has taken appropriate action. The motion passed unanimously.

Dr. Renee Poole asked about how to get feedback from the prior approval reviewer once the medications are approved for a patient. She has found a lack of communication in the process, hearing from HFS only when there is a problem but nothing when there is an approval. She asked what happens after the prior approval request is submitted and what would be the appropriate time frame to check the status of the request.

Mr. Parker stated that HFS has set up an on-line system to check the status of prior approval requests. It allows the provider to see that a request was received and gives information on the status including the final disposition. If staff have a fax number from the requesting provider, he believed they would fax a response back. The prior approval unit would prefer that providers use the online system to check the status. He noted that staff are making decisions on prior approval requests within 24 hours. He added that if a request is faxed or phoned in, HFS staff must data-enter it and a provider should figure about a half day before it appears in the online system.

Eli Pick suggested that the MAC may want to try a short monitoring period where the Department reports back on a pilot number of cases including the length of time it took to resolve. The thinking is that it would be good to look at data rather than just depending on general perception.

Linda Shapiro saw two issues. One is the approval and the other is the communication back to the provider so they may care for the patient in a timely way. She would like a response from HFS that would address both issues. It would work best if the Department already has something in place that it can share with the MAC.

Mr. Parker suggested putting this on the agenda for the next meeting and asking Lisa Arndt, who runs pharmacy, to see what is in place. He added that the biggest bottleneck occurs when prior approval requests are telephoned or faxed in. He noted that HFS does monitor the phones for busy signal and dropped calls, and monitors the time from data entry to adjudication.

At the Chairperson Gordon's request, HFS will email MAC members with contact phone numbers to resolve a prior approval problems now as the next meeting is not until March 8.

V. Director's Report

Mike Koetting reported on progress with the expansion of Medicaid under the ACA. The expansion will bring in people without dependent children and income at or below 133% of the poverty level. This will free up an enormous amount of funds for the state of Illinois to pay providers for these individuals' medical care. The money will help to defray the cost of local government that spend money for local community health boards, the Cook County Health System, and Disproportionate Share Hospitals that lose some funding under the ACA. HFS has seen broad support from the provider community and insurance groups for the Medicaid expansion although the legislation (HB 6253) didn't pass as the lame duck session was focused on the pension reform issue.

The new bill in the new legislative session is Senate Bill 26. HFS urges everyone's support on that. The Department anticipates that there will be basically two bills. The first, SB 26, we need to get passed as soon as possible as it establishes the new ACA group. There will likely be a second bill to clean up several aspects of the Public Aid code to be ready to implement the ACA in Illinois.

Selma D'Souza, Chief, Office of Legislative Affairs, thanked providers for their support. HFS anticipates a Senate hearing during the first week of February and then it goes on to the House. There is a focus on downstate Democrats and Republicans. There are about 35-40 new legislators to teach about the bill. She encouraged people to join the coalition and advised that the HFS website would be updated with new fact sheets on the bill.

Mr. Koetting gave an update on efforts to establish a state run Health Benefits Exchange. He advised that Senator Koehler has filed SB34, and the administration is looking at it. There will be a bill to establish an exchange. The state is doing procurement for an operating system and is confident that if a bill is passed this session, we will be able to establish a state based health exchange by October 2014 and effective for January 2015.

Q: Dr. King stated that her understanding is that the Medicaid expansion is a way to improve access and encourage providers to sign up. Is there a plan to assess and monitor this program to see if it makes a difference?

A: Mr. Koetting responded that there are a number of federal plans to assess this and would provide the most data. Mr. Parker added that the simple way to measure access is through increased billing of certain claims. HFS monitors provider participation. It looks at providers enrolled and then at three levels of time based activity that include participating, non-participating or inactive. HFS can also look at the volume of provider activity.

Q: Dr. Edward Pont asked how HFS can track payment when the capitated rate doesn't square well with the Department's current payment methodologies? He was disappointed that the supplemental payment for providers to bring total payment for services up to 100% of the Medicare rate was going to be a lump payment distributed quarterly and that it would go to the MCO to distribute rather than directly to the provider.

A: As far as measuring increased access and participation on the Managed Care side, HFS would do that the same way as it would do it on the Fee-For-Service side, using the encounter data passed to HFS from the MCOs. This was a problem in the past with the voluntary MCOs because physician payments were capitated so they tended not to send their encounters to the MCO. HFS and MCOs now expect that since the encounter data generates additional payment that it will be submitted by the physicians that are the sub-capitated. With the data given to HFS on a claims level detail basis, we can measure access by seeing how many doctors are billing and how many services they are providing.

On the payment mechanism in the FFS system, there will be a delayed retrospective adjustment to claims. Part of the reason for this is the programming needed to do that and the registration process to get doctors to do that is just not up and running yet. The final rules didn't come out from the feds until November but they did fix many of the problems that were in the proposed rules. Also HFS doesn't want to pay the supplemental claims out of the GRF.

On the MCO side, HFS had originally proposed payment directly to the physicians. CMS rejected that and required that the payment go back as a lump-sum to the MCOs. The CMS position is that the payments HFS makes to the MCO is payment-in-full for services to MCO enrollees. HFS is taking every encounter that qualifies and multiplying it by the supplement for that code, then sending that supplement back to the MCO with a file stating the amount that goes to each doctor for the claim it is based on. The MCO must certify that 100% of the supplement has gone back to that provider. This is an auditable process enforced by HFS as a legal requirement to certify they have complied and by the CMS as federal law.

Q: Andrea Kovach asked about the status of the Enhanced Eligibility Verification project as mandated by the SMART act, aka the Illinois Medicaid Redetermination project.

A: Mr. Koetting stated that there will be a complete report at the MAC Access subcommittee meeting on January 15. He advised that the data matches have been done. HFS and DHS are working out some glitches in the way we set up queues. HFS anticipates that the first group of letters will not be a large number and will go out around January 21. Also, the call center is open. The first group of cases reviewed will be high-priority cases which means ones that HFS believes has a high likelihood of ineligibility.

All clients will get a chance to return correct information and respond to data that HFS has received electronically. There will be an appeal process. He added that he has been explaining to legislators that just

because someone shows up with $70,000 in income in the past doesn't mean that person is still earning that amount. It is likely there will be a fair amount of clients taken off the rolls in March and April. He suspects that a reasonable number of clients that come off have not used Medicaid in a while as they have moved out of state.

Q: Ms. Shapiro asked if members are going to get a posting on the process and specifically the letter that goes to Medicaid beneficiaries. If there is something in writing, can it be found on the website?

A: The letters should be the same as the Department mails out now and will be available in English or Spanish. The call center has 20% bilingual staff. HFS did put together a three page letter for potential client assisters that tell when the call center is open and where people have to go. It should be on the website. Because of the finite time that a client has to respond, it is important to review the time frames on the letter to encourage a timely response to the Illinois Redetermination project or local office.

Q1: Dr King had asked that MAC meetings be accessible to the public by telephone and the web and in a more meaningful way. She believed that federal match is available to involve beneficiaries in this process. What is the status of that request?

A1: Chairperson Gordon responded that she believed that Teresa Eagleson, Administrator, Division of Medical Programs, had sent a letter out regarding the request. HFS staff researched this and it was determined that the cost at $40,000 made it prohibitive. The Director decided it was not feasible.

Q2: Looking at the Medicaid law under the section of managed care, the state is responsible to have a quality program and strategy. Part of the quality strategy includes getting feedback from beneficiaries. Dr. King asked how this is happening.

A2: Chairman Gordon responded that at the recent Care Coordination subcommittee meeting, the Director had discussed the Department's quality efforts and the transparency in the process. Mr. Parker stated that HFS has a state-wide quality strategy for managed care. Managed care contracts require that plans have consumer advisory boards. The Department is measuring MCOs and CCEs on quality measures. HFS has continued to look for quality measures for Long Term Supports and Services in respect to quality of life. Before January 24, HFS will post a list of quality measures for discussion. HFS has created a new bureau on quality issues. Over the last several years, HFS has had stakeholder meetings that have included beneficiaries in respect to the move to managed care. A primary discussion point has been finding quality measures and other consumer safeguards. HFS has had significant beneficiary input into those topics.

Dr. Pont stated that although the measures will be done, the concern is that they will not have an impact. For example looking at the ICP evaluation, you see that one plan did a little better than the other but it is not clear that the reimbursement cap rate that HFS pays them has changed. The way to make these measures have force is to make them public. It has been suggested several times that we have some website, especially as enrollees have multiple care choices in a geographic area, where we can identify how these different care coordination entities are doing. That is where the measures would be more meaningful. The concern is also continuity of care so a new enrollee can connect their existing provider to a care coordination plan.

Mr. Parker responded that the Integrated Care contracts and the 30 measures including the dozen that are pay for performance are up on the website. However, HFS doesn't have the HEDIS results yet because those are done on a calendar year basis so there is a lag. Not only will the scores be posted for the plans but in the future, the assignment algorithm will be quality based. The better a plan does on the HEDIS indicators the more enrollments they will get and fewer enrollments if they do worse. There is also 5% of the capitation rate in a withhold pool that plans may only earn by showing improvement on the measures. The contracts have a minimal performance requirement so that if they regress backward beyond a baseline on one of the measures they will not get the bonus on any of the measures. When we have comparative scores, the client enrollment broker will include these scores to help the enrollee make an informed choice. Charts won't show which plan a provider participates in. The hospital list is out there but the physician list is too cumbersome so that discussion occurs when the person contacts the Client Enrollment Broker.

Q3: Dr. King asked how is the Department responding to what is going on with the flu.

A3: Chairperson Gordon asked that this issue be addressed later when new items are open to committee.

VI. Member discussion regarding copays

Chairperson Gordon stated that Andrea Kovach had made a motion that was passed at the last meeting to add an agenda item to discuss copay issues in the SMART Act and that MAC members would come prepared to present their constituents' views about it. She added that the Director has said that she is open to continuing the process of looking at copays and the impact on care.

Ms. Kovach stated that she had reached out to staff at legal aid organizations to see if they had heard of access issues regarding copays. She heard that some staff are just starting to hear reports of clients who have been negatively impacted by the imposition of copays, specifically on not being able to get medications. Legal Aid staff will start collecting data on that. Some providers said they have patients that were discharged from provider practices for failure to make the provider copays. There are also some reports of inconsistent imposition of the copays by providers on different patient groups. Some charge copays and others do not.

Ms. Kovach plans to check with other legal aid organizations in the state before the next MAC to see if they have any actual data on clients having problems with this issue. She is also interested in learning from HFS if they are planning to do any data collection around the impact that the imposition of copays are having.

Dr. King stated that when there is a change in the payment rate and method that under Medicaid law, the state has a responsibility to measure how that impacts access to care, whether it be to clinics or medications. The feedback she is getting from beneficiaries and providers is that people have had difficulty coming up with the copays for medications. She also found that there is confusion for providers on when and to whom to apply the copays. She asked that HFS re-post the Q & A that she had received on when it is appropriate to charge copay.

One issue of concern is the ER copay when the visit turns out not to be an emergency. There is a charge that varies based on the income of the eligibility group. For example for All Kids Share with income greater than 133% of poverty up to 150% of poverty, the charge is $10. When Dr. King looked at the CMS recommendation, the amount of only $7.80 was allowed. She questions why the state charges more and how it can charge more when Illinois' State Plan Amendments (SPA) has been approved as yet. She would also like to see Illinois post its State Plan Amendment with as much transparency as some others states are doing.

Chairperson Gordon added that Lurie Children's Hospital has submitted a letter to Director Hamos seeking clarification on charging copays for the non-emergency use of the ER as there is not a definition of emergency care. The hospital is not charging the ER copays as it is not sure when to apply it. She asked Mr. Parker if it is true that HFS may not collect copays because HFS doesn't have approval of the SPA as yet.

Mr. Parker responded that HFS has authority to impose the copays because it has filed the SPA which reserves the effective date. It is standard to implement state plan changes once you file the SPA as the process to get approval from the Feds can take many months. Some of the SMART Act SPA are approved but most are not. He stated that HFS has made one change in the policy on the ER copays. HFS had originally imposed the non-emergency use of the ER copay on children but has now decided to stop that policy for Title XIX (Medicaid) children. The computer programming should be in place in a matter of days. The pre-existing copays on Title XXI (Share/Premium) children are imposed regardless of whether it is an emergency or not, although the copay is higher if the ER is used in a non-emergency. The copays have always been applied for higher income children covered under Title XXI. When a provider bills for ER level 3, which is the lowest level of care, the copay applies as level 3 indicates that the service was for a non-emergency.

Dr. Margaret Kirkegaard stated that there is still a great deal of confusion among providers about how and when they can and should collect copay. She would encourage HFS to put out additional provider education materials to make it clear, not create confusion at the provider's front desk, or turn patients away from care.

She stated that a concern brought to IHC from providers is about whether or not to waive copays, especially if waiving the copay represents fraud. Providers feel caught between providing good care and committing fraud which would bring retribution on their practices. She would encourage HFS to clarify that in a communication to

providers.

Mr. Parker advised that HFS would get something out to providers on copays. The law in Illinois is still the Medicaid law that you must provide the service even if the patient says I can't afford to pay my copay. This means there are circumstances when you may waive the copay and some that you must waive the copay.

Ms. King noted that in legislation the year before the SMART Act, there was an SPA to allow pharmacists to not provide medication if the patient didn't provide their copay. It is important to inform the beneficiaries of their rights and for the Department to monitor the impact of these copays. She also pointed out that there are some new copays in the Illinois Healthy Women program. A recent study by one of the quality agencies showed STI (Sexually Transmitted Infection) screenings were less than 60%, and 80% of women that had a positive screen did not have screening for syphilis or HIV. There were very low rates of STI counseling. The point is that there are copays for family planning related visits that takes a situation where people are not getting care and then adding another barrier.

Sue Vega commented that it is also imperative that we get information on the copays for AABD older adults. We know collection of copays is having an impact, especially with persons getting medications from a big chain pharmacy and the pharmacy staff say this is the amount you will pay and this is what the computer says and the client is not going to get the medication without making the copay. This is a real issue.

Dr. Poole commented that in regards to the issues Dr. King has brought up, it sounded as if these are women going into the ER for STD testing. She believes that we need to integrate these individuals into a primary medical home. If they are not being integrated into a medical home, we should look at ways to redirect those patients into a medical home at a primary care facility.

Chairperson Gordon asked that Mr. Parker or another HFS staff report at the next meeting on how HFS is communicating to providers and clients about this issue.

VII. Subcommittee Reports

Access Subcommittee Report: Mr. Pick reported that the last meeting was November 19. The subcommittee reviewed the October 24 briefing session that included the participants identified as subcommittee members as well as interested parties. The group reviewed three options for setting Essential Health Benefits for persons insured through the health benefits exchange and Benchmark Medicaid for new enrollees. Options included the standard Medicaid package, the standard package without Long Term Supports and Services (LTSS) and the comparable to employer sponsored healthcare plans with some LTSS to meet needs of special populations.

HFS asked participants to identify specific services that they thought should be included in the benchmark Medicaid package. There was robust discussion on this topic.

The group looked at the cost analysis supporting the Medicaid expansion. There was discussion about persons covered who are getting services from departments paid by other than Medicaid. HFS requested support at the legislative process for approval of the expansion.

The group discussed meeting logistics and the next meeting is January 15, 2013 from 11a.m to 1 p.m.

Long Term Care (LTC) Subcommittee Report: Kelly Cunningham, Chief, Bureau of Long Term Care, reported that the last meeting was December 14. She provided a summary of activities of the three meetings in the past year. The committee looked at rebalancing of the LTC system which is directed toward initiatives that seek to increase dollars and attention to home and community based services for people otherwise eligible to live in LTC institutions.

We spent time talking about implementation of the Money Follows the Person (MFP) program which the state kicked off in July 2008. HFS began transitions in February 2009 and has transitioned about 700 individuals

across aging, persons with disabilities, people with serious mental illness and, very recently, people with developmental disabilities out of state operated facilities.

We discussed the growth of our home and community based waiver programs from a utilization and spending perspective as well as looking at some of the new requirements that the federal CMS has put on these programs in terms of enhanced quality improvement.

We talked about the SMART Act and some of the issues and challenges of implementation that impacted LTC and generally focused around rate reductions.

In our most recent meeting we discussed the care coordination roll-out and what the Department's plans were in terms of innovations and care coordination activities. We spoke specifically about the Integrated Care program Phase II changes rolling out in the next couple of weeks that incorporate Long Term Supports and Services.

We had updates from our Division of Developmental Disabilities regarding several state operated facility closures, specifically Jacksonville that was accomplished over the fall and Centralia which is scheduled to begin this year. We will try to maximize our MFP program for persons affected by those facility closures.

We adopted our meeting schedule for this year and it is posted on our website. The next meeting is March 22.

Public Education Subcommittee Report: Kathy Chan reported that the committee last met on December 13. A big part of the meeting was discussion of the Integrated Eligibility System and getting progress updates from DHS. There is a lot of work being done to make sure that databases are coordinated smoothly and built in a way that is thoughtful so programs are working together to share information and make sure we are ready for the influx of newly eligible.

Some of the updates that may be of interest are that DHS was involved with design sessions in accordance with the other departments, and that Illinois is looking at adopting a system that is being used in Michigan right now. There will be a worker portal that will be one system and there will be connections to different state and federal data hubs. This will allow us to move toward a more paperless system as we use more data matches to complete applications. A next future phase is to replace cumbersome backend processing procedures that have a lot of paperwork and direct client interaction. It is anticipated that by 2015, clients will complete redetermination forms online and be able to check the status of their case.

There was a discussion about data available from the Department. HFS staff, Tia Sawhney presented about data that could be made available and talked through how to get some of that data as well as some of the limitations.

Maximus staff did a presentation about the Illinois Redetermination Project and talked about what their process will look like. We anticipate hearing a lot more at our next meeting on February 14 from 10 a.m. to noon. We plan to meet every other month in 2013 and there is a meeting calendar online.

Care Coordination Subcommittee: Dr. Pont advised that he wasn't at the last meeting but understands that it was a very good meeting with four of the six new CCEs presenting on how they intend to manage care and improve the medical health of enrollees. Several ended their presentation saying they hoped they could take care of all Medicaid patients. It is great to hear that kind of enthusiasm.

There was ER utilization data presented and it is causing some confusion as to whether or not we are seeing a decrease in ER utilization as a result of the SMART Act and if decreases in Medicaid enrollment account for the decrease. It would probably be in everyone's best interest if HFS could clarify what those numbers mean.

Mr. Parker commented that we had talked about this at the meeting and there were requests to cut the data in additional ways which HFS is going to try to do. We cautioned that though the chart shows decreases in ER usage, it is still at a point in time where much of that decreased usage is simply a matter of billing lag. HFS has a requirement for providers to bill within six months rather than one year. So we expect to have more complete

numbers in the report. HFS also plans to cut the data by a couple of specific diagnoses. One of these is adult dental to see if there is an increase in ER dental utilization.

Dr. King advised that she had raised a question about individuals incarcerated, who are then released, if they are being maintained. This is a population that should be considered for care coordination to make sure they have benefits and are tied into care. There is concern that persons released and subject to redetermination will lose coverage. A couple of questions that she still would like to ask the CCEs are how they define cultural competency and data about hiring people of color.

The next Care Coordination subcommittee meeting is February 5 from 10 a.m. to noon.

Chairperson Gordon thanked all the chairs of the subcommittees for their good work.

VII. Update on SMART Act 2840

The thing in the SMART Act that Department staff are currently spending the most time on is the 340B requirements. For most of the other things like the four-script rule there is nothing new to report. All of the SMART Act Initiatives were put into rule by the extraordinary emergency rule power given to HFS. These will be converted into regular rule making in the next ten days or so. This movement will open the rules to the public to make comments. There will be some changes, with some of the rules slightly changing, based on experience, plus the Department will be putting into some of those rules initiatives, or things, that we could not put directly into the SMART Act. Mr. Parker encouraged people to watch for those filing as they'll be able to make public comment.

Q: The Emergency rules are in effect as the regular rules go through. Is it correct that the changes added for the regular rules will not be in effect until after JCAR approves them?

A: Yes. Anything that will be a regular rule has to go through the full process before it will be in effect.

IX. Update on Care Coordination Initiatives

Innovations Project: The solicitation to take care of complex children has gone out. Letters of Intent are due fairly soon.

Dual Medicare/Medicaid Care Integration Financial Model Project: The plans have been selected and the Department expects to have the Memorandum of Understanding with CMS signed by the end of this month.

Cook County 1115 Waiver Demonstration Project: Mr. Parker stated that the waiver is in place and approved. HFS is working on getting the details of billing from Cook County through us. He believed that they are starting to enroll people now. Mr. Koetting added that he believed the process is still on schedule.

X. Open to Committee

Dr. Poole asked for an update on the limitation of access to intrauterine contraceptive devices (IUDs). Mr. Parker stated that HFS required that IUDs no longer be billed through the pharmacy system as it was paying for a lot of IUDs that were ending up in storage. HFS required that it be billed by the physician who was implanting the device. This caused problems for FQHCs because they could not bill the Department for IUDs. HFS filed an emergency rule right toward New Years which allowed FQHCs to bill us outside of their encounter system for IUDs and the access issue was taken care of.

Chairperson Gordon mentioned that credentialing of physicians is supposed to become much harder and slower as a result of a new provision. She asked that people pay attention to this as it is really serious. The staffing to do credentialing is being reduced from something like eight to only two or three people processing all the applications for doctors in Illinois.

Q: Dr. King asked if HFS has any responsibility to look at what is going on in public health. Is the agency aware of how well beneficiaries are able to access the flu vaccine? Are there messages that come out from Illinois Health Connect?

A: HFS Medical Director, Dr. Arvind Goyal thanked Dr. King for raising the concern. He stated that HFS pays for the flu vaccine. There has not been a shortage this year with millions of doses available. He stated that he had met with the Director at the Illinois Department of Public Health (IDPH) and he is aware of their efforts. He did not believe there is a shortage in spite of the increased number of cases reported in the last month or so that have created some rise in hospital admissions. He does believe as far as Department support is concerned that HFS would welcome feedback and is willing to put information on the website or take action to better serve patients and beneficiaries.

Dr. Poole added that there was a press release by IDPH regarding the severity of the flu. She knows that there are some shortages at some clinics. It would be great to get information out there to the public to encourage people to get the flu shot.

Mr. Parker stated that the Director wanted people know that there is a meeting in Chicago at the JRTC, large first floor auditorium on January 24 from 1 p.m. to 3:30 p.m. The meeting will cover the roll-out of Long Term Services and Supports into the Integrated Care program beginning February 1. Representatives from the two health plans and state agency staff will be there. The presentation is designed for consumers and providers to get information about how things will work. HFS will be posting some Q & A ahead of time. Most persons on our Listserve would have received an invitation in the last day or so.

Chairperson Gordon asked members to review the list of MAC suggested agenda items before the next meeting so they could be discussed.

XI. Adjournment

The meeting was adjourned at 12:05 p.m. The next meeting is scheduled for March 8, 2013.