Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
January 20, 2012

Members Present
Susan Hayes Gordon, Chairperson
Eli Pick, Post Acute Innovations
Judy King, M.D.
Mary Driscoll, DPH
Edward Pont, M.D., ICAAP
Deila Davis for Linda Shapiro, ACHN
Karen Moredock, DCFS

Members Absent
Kathy Chan, IMCHC
Alice Foss, IL Rural Health Assn.
Glendean Sisk, DHS
John Shlofrock, Barton Mgt.
Sue Vega, Alivio Medical Center
Andrea Kovach, Shriver Center
Renee Poole, M.D., IAFP

HFS Staff
Theresa Eagleson
James Parker
Jacqui Ellinger
Lynne Thomas
Robyn Nardone
Tia Goss-Sawhney
Shelly Defrates
Andrea Bennett
Sally Becherer
Lora McCurdy
Ann Lattig
James Monk

Interested Parties
Julie Billingsley, Magellan
Elizabeth Brunsvold, MedImmune
Kelly Carter, IPHCA
Christine Cazeau, IHC
Caroline Chapman, LAF
Joe Cini, AHS
Gerri Clark, DSCC
Laurie Cohen, Civic Federation
Mike Colip, Independent Care Health Plan
Cathy Cumpston, DHS/DMH
Robert Currie, Aetna Better Health
Danielle Dalessandro, Strickland & Assoc.
Diane Fager, CPS
Andrew Fairgrieve, HMA
Gary Fitzgerald, Harmony
Eric Foster, IADDA
Matt Hartman, HCCI
George Hovanec, Consultant
Nadeen Israel, Heartland Alliance
Margaret Kirkegaard, IHC
Mike Lafond, Abbott

Interested Parties
Phillipe Largent, LGS
Kim Luckey, Lawrence Hall
Mona Martin, Phrma
Susan Melczer, MCHC
Heather O'Donnell, CJE SeniorLife
Karen Osuch, FHN
Debbie Pavick, Thresholds
Jennie Pinkwater, ICAAP
Mary Reis, DCFS
Camille Rodriguez, IARF
Dan Ryan, Vermillion Cty Mental Health
Bonnie Schaafsma, IADHA
Ben Schoen, Meridian
Jo Ann Spoor, IHA
Chester Stroyny, APS Healthcare
Jessica Williams, CPS – CFBU
Julie Youngquist, Lawrence Hall

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
January 20, 2012

I. Call to Order

Chairperson Susan Gordon called the meeting to order at 10:08 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Review of November 18, 2011 Meeting Minutes

The minutes were approved as written.

IV. Director's Report

Theresa Eagleson, HFS Medicaid Director, reported that the Innovations Project Phase 1 solicitation should be out next week. The department has received a lot of great feedback from stakeholders and looks forward to hearing back from the provider community and provider networks to help us improve the system.

Ms. Eagleson indicated that the department has started working on the budget for 2013 and the outlook is not good. If people have ideas for efficiency without reducing quality of services, HFS is interested in hearing about the ideas.

V. Update on Dual Medicare/Medicaid Care Integration Financial Model Project

James Parker, Deputy Administrator of Operations, advised that the federal government had accepted Illinois to be part of their financial realignment for the integration of care for dual-eligibles. Medicare and Medicaid would work closely to reduce costs and improve healthcare outcomes. There are two models, managed fee-for-service and dual capitation. The managed fee-for-service model is directly tied to the Innovations Project where the state will set up a system that manages fee-for-service care rendered to dual-eligibles with sufficient care coordination functions. There is very little detail about the federal requirements to approve the plan, but if approved the federal government would share Medicare savings with the state.

HFS feels that everything we've asked for in the solicitation for Phase I of the Innovations Project is exactly what managed fee-for-service is all about. Our plan is to take what is successful from the Innovations Project and seek federal approval for the dual-eligible population. The federal target for implementation for the managed fee-for-service model is January 1, 2013; which is a softer target date than for the dual capitation model.

Under the dual capitation model dual-eligibles would be enrolled with HMOs; which would be responsible for administering all Medicare and Medicaid covered services. The federal model is an "all in" model, where like the Integrated Care Program as we go down the road to phase 2, will include long-term services, including nursing home services and waiver services. There would be no carve-outs from the capitation rates. The state and federal CMS would go through a selection process choosing an undetermined number of HMOs to cover dual-eligibles in some, yet to be determined, parts of the State. A consideration in determining what parts of the state will be included is where there are plans willing to participate.

The federal timeline for the dual capitation model is to have the program running with coverage beginning no later than January 1, 2013. This is a much harder deadline than with fee-for-service model because it is tied to the Medicare Advantage and Medicare part D open enrollment period. In order to allow dual-eligibles to make their choice on plans and have enrollments switched by January 1, 2013, the feds must identify the plans by late summer so they can have educational materials ready for the open enrollment period beginning in October 2012.

A lot of states, including Illinois, have said that the timeline is too fast. CMS has indicated that they were rethinking the timeline, but keeping a January 1st start date. It is difficult to characterize the federal position. They have indicated that they are open to states requesting to begin a year later on January 1, 2014. But, they haven't indicated that a state could a have start date anywhere in between. HFS is not sure of all the issues as duals always have a special enrollment period and CMS has indicated that even in this model, there would be no lock-in, which would allow dual-eligibles to disenroll on the Medicare side at anytime. The state needs to make a decision, hopefully by next week, as to whether we will pursue the 1 or 2 year track. The department welcomes input on that. The department took several follow-up questions on this initiative.

Q: Will the Innovations proposals designed to serve dual-eligibles have any sort of priority?
A: At this point, we haven't considered giving any priority to proposals that cover duals. What we are looking for would meet both our needs and the feds as the duals are part of the priority population for this solicitation.

Q: When you said there are no carve-outs in the dual capitation model, does that mean those HMOs will have to provide all services including mental health and dental services?
A: Yes, they will need to cover to the extent that Medicare and Medicaid cover those services today. There would be no mental health carve-outs but keep in mind that our coverage for dental for adults is not that broad today. Since there are no carve-outs for the Integrated Care program, HFS hasn't asked about the flexibility of carve-outs for this plan.

Tia Sawhney, HFS' Director of Research, Data and Analytics, believed that CMS would be reluctant to change coverage for full Medicare benefits, but that there may be some flexibility to carve-out some of the Medicaid benefits.

VI. Update on Innovations Project

- *Performance and Quality Measures*

The Innovations Project solicitation has a number of quality measures. There are some pay-for-performance (P4P) measures tied to care coordination fees and some other measures tied to shared-savings. There is also a set of measures that are not tied to P4P. The measures tied to the care coordination fees would be considered utilization measures, such as inpatient admission rates, ER utilization rates and follow-up after discharge. The measures for shared savings are less utilization based and more quality based. As of now, these measures are; patient review, access to primary care, and behavioral health follow-up after an appropriate diagnosis.

A factor influencing the measures is very limited information from the federal government. They have indicated that shared savings must be tied to metrics are quality measures rather than utilization measures. The desire is to find broad based measures, which is challenging because HEDIS measures tend to focus on specific diseases. Since we are trying to select a limited set of measures to tie to P4P, you start splitting that pot into a whole lot of tiny little pieces and it ends up that money is being tied to what could be a very narrow segment of the population. For example, you're serving 1,000 people and 200 have diabetes, so all your P4P is tied to how you treat those 200. The department continues to be very receptive to ideas about what we could measure that would be more of the entire population that is more quality based.

It is easiest if we measure on claims data. Things that require the department to go out and measure by reviewing records or doing an audit are more difficult. Medication management is a goal for shared savings, but we are still trying to figure out how to measure and document it because it is neither a HEDIS measure nor claims based. We're talking about a record for every patient that takes 5 or more medications for 2 consecutive months and a review being done for the appropriateness of those medications, looking for interactions and, if feasible, a plan to reduce those medications. This would be an excellent care coordination function for people that are on 9 - 12 medications. There is no claims data to see if this has been done, but it important enough to try and figure out how it can be measured. We are open to suggestions even after the solicitation is issued, because we indicated that we are still looking for better measures and are very interested in measures that are

broader based and care coordination focused. You can submit comments via our website by choosing the link to "contact us".

A meeting participant asked how access to primary care was going to be measured. The group was advised that it would be based on a preventative visit per year to the PCP or a preventative code visit. Mary Driscoll stated that the Department of Public Health (DPH) has a data map available on their website that looks at ED visits put through an algorithm that is primary care sensitive. About 60% of the ED visits in Illinois are primary care sensitive in one way or another and gives a clue to access to primary care. This information is available by payer mix. Mr. Parker added that when the department looked at utilization measures, we originally had a measure that was labeled "Percentage of ED visits that represented a true emergency." We decided to use just "Number of ED visits," assuming that if patient care is managed well, both true and unnecessary ED visits would be reduced. Part of our reasoning to use # of ED visits was the difficulty in determining which visit is an emergency and which one is not. It would be good for HFS to see how that is determined at DPH.

A meeting participant asked for clarification on the department not being sure it could follow persons on five different medications, since pharmacy claims are tied to a patient. Mr. Parker explained that we can identify participants on five medications, but the problem lies in determining if a comprehensive medication review that includes an intervention plan was performed. The department is hesitant to have providers just give us a number. In addition, at this point, we don't know how many CCEs we are going to be measuring. The more entities, the more difficult it is for the department to do any on-site monitoring or record auditing.

One of the metrics identified is follow-up after a behavioral diagnosis. In pediatrics that is restricted by the dearth of childhood psychiatrists and therapists. A meeting participant asked if the department would consider as a valid alternative the primary doctor following-up with the DocAssist hotline. The department clarified that this solicitation is for adults only. There is one coming out in the future that will be for children and will include some differences in the quality measures.

Clarification was requested on whether the solicitation for children would be only for children with special healthcare needs or if it would be broader. The department explained that the main reason that solicitation is not going out with this one is the same definitional problem. First, the department is not sure how it will define special healthcare needs today. We expect the definition to be broader by speaking of children with complex needs or chronic conditions that are moderate to high cost. There is a committee looking at the complex needs children that will meet next Tuesday. Information on the committee can be found on the HFS website.

In this first solicitation, every proposal will focus on and serve the target adult population. However, HFS will allow bidders to include children to the extent that they are family members of the population served, with some restrictions that are explained in the solicitation. We'd also allow enrollment of the other adults that we cover, basically the parents. The care coordination fee for the healthy adult or children will be a different rate than the rate for the complex population. The current solicitation will not have a P4P for the children.

A meeting participant asked if, on the mental health metrics, providers for follow-up will be limited to psychiatrists or will it be open to mid-level professionals like social workers. Mr. Parker indicated that the follow-up measure is a standard HEDIS measure; he didn't think it was limited to psychiatrists and believed follow-up may occur with a PCP. If the PCP visit has a primary mental health diagnosis code, we assume that visit was the follow up treatment. There will be a separate data definitions document with the full solicitation. The definitions will also be posted on the website.

Dr. Pont added that the performance measure for behavioral healthcare coordination risk assessment and follow-up given out at the November care coordination meeting didn't indicate a specific provider.

A meeting participant asked if there is an assumption that if a person has access to primary care they have access to specialty care. Mr. Parker responded, no, and explained that the reason access to primary care was

chosen is that it's a requirement that covers every single person enrolled. All the models will be required to have medical homes; and if you begin with prevention, then you need to be seeing your PCP.

- *Status of Solicitation*

HFS will not do a mandatory bidder's conference. The department will issue the solicitation and depending on the feedback, type and frequency of questions received, we may conduct some kind of webinar. The department has put together a "match making" link on the Care Coordination web page. The match making feature will allow community partners to identify other organizations who may be interested in forming a collaboration. HFS encourages people to sign up even if the already have a collaboration underway to share where their interests are and to see where people are already working on these proposals. The department is also going to have people submit letters of Intent (LOI) by February 29th that describes what their collaboration will look like. The match making link is:
http://www2.illinois.gov/hfs/PublicInvolvement/cc/mm/Pages/SubmitMatchmaking.aspx

Several participants indicated that it would be helpful to have a list of organizations that submitted LOIs and the target population and geography of interest. Mr. Parker advised that the department hadn't decided how it would make the LOIs public and would need to discuss that internally.

Clarification was requested on whether a list would be available as the state moves from a LOI to an actual procurement, or at what point will people know that the state is considering their proposal seriously. Mr. Parker indicated that HFS outlined some minimum requirements in the LOI and that a process is needed to screen those. A reason we are asking for so much information in the LOI is so the department can advise people if they're on the wrong track, or if the proposal is too narrow, or doesn't focus enough on comprehensive care coordination.

A meeting participant asked if HFS has a perspective on the priority geographic areas and populations. It was explained that the Innovations Project is a statewide solicitation, with no priority geography. There are some limits for the Cook suburban and collar counties where the Integrated Care program is already operating. The solicitation does say that we especially welcome proposals serving persons with serious mental illness and substance abuse.

When asked if there is a cap on the number of solicitations the department would accept, Mr. Parker responded, no cap, but there is a limit to the department's capacity to track, monitor and exchange data with entities.

- *Status of Data Development*

Tia Goss Sawhney, HFS Director of Research, Data and Analytics, stated that it is highly unlikely that anyone will be able to prepare a proposal without data. The department's goal is to give people data that is meaningful, appropriate for pricing, and consistent. The earliest date that data would be available is February 15th.

Ms. Sawhney explained that persons must complete the Letter of Intent (LOI) to get population data. The LOI has multiple purposes. HFS will ask potential bidders to describe what they want to do, the target population, who the partners are and questions like who you are, how you're going to manage this financially and how you're going to manage the full spectrum of care. The purpose is, in part, to see if the potential bidder is on the right track or in need of guidance. HFS will prepare a data set for the target population within the parameters we have available. For example, some people wanted to know about homeless people, however, there is no code on the Medicaid system that tells if someone is homeless. There were requests for very specific ethnic background information. We don't have that. We have standard federal reporting ethnic categories of Hispanic/non-Hispanic, Black, White, Asian, etc and they have all the normal limitations which include that it is self-reported data. HFS can tell who has serious mental illness or substance abuse problems.

The department would give each bidder two data reports. One would be for the target population for care coordination and the other could be for everyone in the geographic area including the non-priority persons. It will be summarized data. There will be one record per recipient and over 300 data elements per person. The record tells what program they're in, if it is a waiver program, and breaks out costs and services with a fair amount of detail. It will have Chronic Disease Prediction System (CDPS) flags which is a risk adjustment system. We're not using the model for risk adjustment, but to set chronic condition flags based on the 2010 claims. HFS takes all the diagnosis associated with the recipient and runs it through CDPS and that way determines who has diabetes or heart disease with some measure of severity within disease categories.

Each report will have 3 tables including a recipient table (not zip code specific), provider table and distribution table showing recipient distribution by zip code and age band. The provider table will show only providers serving the recipients in 2010 with the volume of services for each provider and the type of services. The information is what HIPAA defines as limited as recipients are identified by geography but not by individual. One of the things included in the LOI is a data use agreement authorizing the data use for the specific limited purpose. Ms. Sawhney clarified that data could be requested for the target population and then for the entire county.

It was noted that a drawback identified at the MAC Care Coordination Subcommittee meeting, was that the type of service wouldn't have anything as detailed as CPT or DRG codes. Clarification was requested on what detail for type of service will be provided. Ms. Sawhney responded that there are about 50 types of service that are quite detailed. For example for inpatient hospital, there are categories devoted to long care institutions such as psych hospitals and institutions for the developmentally delayed. For acute hospital care, we have maternity deliveries and non-deliveries, newborn care, psych care, substance abuse care. For professional services we have PT, OT, doctor's visits and transportation. We believe that when you load the data you'll find meaning in a matter of hours.

A meeting participant asked if an organization is selected as a contractor, would they get ongoing claims data through MMIS. Ms. Sawhney believed that the answer is yes, as the contractor would be a business associate engaged in the delivery of healthcare. Ms. Sawhney said to keep in mind that what is being provided in response to the LOI is pricing data. The data needed for care coordination is patient specific.

VII. Subcommittee Reports

Care Coordination Subcommittee Report

Dr. Pont reported that the subcommittee met on January 10, 2012 and the focus of the meeting was consumer issues. Two important points came out of the discussion; the first was continuity of care and the other was availability of data. Dr. Pont advised that as we move to a new model of care, patients should be able to stay with providers they're happy with. And, in order for consumers to make a good decision regarding enrollment for themselves and their children, they will need data that is organized and easily available.

The October 13 webinar and the November 29th "Q & A" document were also discussed at the meeting. Clarification was received from the department that providers would continue to have the ability to regulate their panel size. There was a lively discussion regarding the department's rationale for its preference for a full risk model and about the data available to potential bidders under the Innovations Project.

A suggestion was made that for the next meeting the subcommittee look at the care coordination experience in Pennsylvania where the Philadelphia and Pittsburg areas are covered by five to six MCOs and the rest of the state is covered by a PCCM. Because of the similarity with Illinois, it could be useful to hear and learn from their experiences.

Public Education Subcommittee Report

Jacqui Ellinger, HFS Deputy Administrator for Policy Coordination, reported that the subcommittee met on December 8th. The meeting was primarily an update on a number of projects the subcommittee has been following.

There was a special presentation from Susan Locke on the Human Services Framework, the enterprise data systems project involving seven state agencies. Discussion followed on how this project fits with the other massive data eligibility system changes being made as part of healthcare reform. Along those lines, the state of Illinois was invited and agreed to participate as one of about 13 states that are consulting on what is called the UX2014 project. Kathy Chan, a MAC member and Public Education Subcommittee member and All Kids Bureau Chief, Lynne Thomas are part of the team. The California Healthcare Foundation, some other foundations and CMS have put a fair amount of money into designing the website for eligibility under healthcare reform. They're not building a website or developing any software but designing what the website should look like, how many different kinds of users there might be and what level of support users may wish to have. Ms. Chan and Ms. Thomas have been to one conference and another is coming up soon. The feedback has been very positive and we are looking at modeling on that design work.

The subcommittee also had a discussion on the integrated eligibility system being developed to support healthcare reform. HFS has consultants on board helping to develop an RFP to procure a Design Development Implementation (DDI) vendor for the new eligibility system. HFS, DHS and DOI staff have spent a tremendous amount of time, thinking about what a new eligibility system would bring us and what kinds of services it would render. The department invited the subcommittee and a couple of other participants to give us comments. We still have the comments on IES from the MAC given last spring. All comments accumulated have been shared with our consultants. We are trying to make this system is useful not only from the state perspective but for consumers as well.

Other subcommittee updates included:

- CHIPRA outreach activities by Beacon Therapeutic, a grantee that focuses on homeless teens.
- The durable medical card which is still an unfinished procurement.
- Long term care eligibility rule changes affecting the senior and people with disabilities population. We solicited help from the committee in updating the materials given to consumers about those changes.

The meeting schedule for 2012 is posted to the website. The subcommittee will meet every other month opposite of the MAC meeting month.

Long Term Care Subcommittee Report

Kelly Cunningham, HFS Deputy Administrator for Programs, reported that the subcommittee met on December 16, 2012. Several opportunities for long term care (LTC) reform authorized through the Affordable Care Act (ACA) or other federal legislation are being examined. These offer an enhanced Medicaid matching rate if the state makes prescribed changes in terms of LTC assessment processes, single point of entry, and looking at conflict-free case management. This is the "Balancing Incentive Payment" program.

Another opportunity is the "Community First Choice" program. This would require the state to add personal care and personal attendant services to our state plan. Currently, these are waiver services only.

The department applied for another federal grant to expand the scope of the Money Follows the Person, nursing home transition and rebalancing program, to Aging and Disability Resource Centers (ADRC) in three areas of the state. Other topics discussed by the subcommittee included:

- Care coordination through the Innovations Project Solicitation.

- The status of three Olmstead driven LTC lawsuits, Ligas, Williams and Colbert and the various state agency responsibilities in these lawsuits. These suits focus on individuals currently residing in nursing homes or other institutions and doing an intensive outreach, identification, assessment and transition plan to move people out of LTC facilities and institutions as appropriate.
- The status of nine Home and Community Based Service waivers. Several waivers are up for renewal this year.
- Money Follows the Person. We are rebranding some of our marketing materials and trying to create a new name for the program that was reauthorized under the ACA.
- In December, there were 133 operational Supportive Living Facilities with about 11,000 units operating around the state and another 25 programs proceeding to certification.
- The nursing home rate methodology technical workgroup started meeting earlier this fall to address the need for revamping the nursing facility rate methodology.
- In terms of LTC providers, only those that qualify for "expedited status" meaning an 80% occupancy rate plus certain cash position criteria, had been paid at all in fiscal year 2012.

The LTC subcommittee meets quarterly and the next meeting is March 12, 2012. People are interested in talking about the Deficit Reduction Act rules changes and their impact on long term care.

Dr. Judy King referred to a report from a year or two ago that showed in certain communities in Chicago the nursing home ratings tended to be at a very low level. She asked about HFS' role in assessing and putting pressure on nursing homes to improve service. Ms. Cunningham responded that HFS was an active participant in the Nursing Home Task Force public hearing and legislative process. HFS works closely with the Department of Public Health, the state's regulatory agency for nursing homes, on conducting licensure and certification activities. From the quality perspective, HFS is very interested in making sure that nursing homes are providing quality care to patients. The department is committed to build in quality measures to incent performance and quality provision of services in nursing homes.

Dr. King stated that under the Williams consent decree, there is to be an analysis of the adequacy of the community mental health network. This is an important resource if you move people out of nursing homes or other facilities. She asked if the analysis had been produced and if it is something that can be shared.

Ms. Cunningham stated that the analysis is a requirement of the Williams implementation plan. The suit is geared towards individuals residing in about 24 nursing facilities that are designated as institutions for mental disease (IMDs). There are about 3,800 to 4,000 people with serious mental illness that reside in these facilities and are subject to the decree's requirements. HFS works very closely with the Division of Mental Health (DMH) on a steering committee, and various other committees.

VIII. MAC Priorities for 2012

Chairperson Gordon reviewed the first two items in the MAC bylaws regarding the role of the MAC as an advisory committee to the department and having the opportunity to participate in policy development and program administration. She stated that this is the big picture and will help as the MAC discusses priorities. Chairperson Gordon noted that the agenda packet contained a thoughtful memo from Dr. Judy King outlining some of the concerns she would like to see the MAC address. She advised the committee that she had reviewed the memo with HFS staff and respond to Dr. King via e-mail. Chairperson Gordon provided a summary of HFS responses:

- In the near term, HFS will work to post on the web the annual reports for CHIPRA, EPSDT and PCCM.
- Posting the Medicaid State Plan and the PCCM statewide provider profile reports will require additional discussion.

- HFS agrees to include in an annual correspondence to the beneficiaries, a notice of the existence of ongoing opportunities for public involvement in the decision making about HFS programs. However, the department will discuss internally as to which mailings to use and will engage the Public Education Subcommittee to assist in developing this message.
- Starting in March, HFS will add a standing item to the MAC agenda called Child Health Quality Measurement Grant.

Chairperson Gordon advised that Dr. King's other issue topics are health disparities, mental health, adolescent health and access to specialty care. She then asked Ms. Eagleson to comment on HFS' top priorities for 2012.

Ms. Eagleson stated that in discussing these with Director Hamos over the past several months, the top four priorities include: 1) Transforming the Medicaid healthcare delivery system that serves Medicaid clients, as well as others, through collaboration and quality of care. This involves major payment reforms in ways that we incentivize how that care is delivered; 2) Right sizing the long term care system and promoting quality care in the most appropriate setting; 3) Integrating and modernizing eligibility enrollment systems, including better communication with clients, and; 4) Containing the growth in Medicaid liability.

Ms. Eagleson stated that both of the first two require a high degree of provider coordination, interagency coordination and client education. There is a lot incorporated into these top four priorities. Included in containing the growth in Medicaid liability and transforming the delivery system is looking at the most complex and most expensive populations and how we deal with those populations from a multi-department, provider and communication perspective as well.

Chairperson Gordon added that what the MAC members would talk about is certain focus areas within those broader goals and how these changes occur in a safe and good way. The topic was opened for discussion.

Dr. King wanted to comment on some of the things she had put in her memo. She stated that it was mentioned HFS will add a standing item to the MAC agenda called Child Health Quality Measurement Grant. She would want one of the meetings to include the CHIPRA quality measures for adolescent care.

Ms. Ellinger stated that it bears some discussion to think about what we plan to do specifically regarding adolescents because the CHIPRA quality grant is really broader. There is a lot of focus on young children and statistics around birth and birth outcomes. The grant priorities are relatively set. There is a lot of work on how we develop new measures and in many respects is a technical grant looking at the infrastructure that supports what we do. When it comes to the content on adolescents, it might bear at least a meeting to talk about adolescents in our program.

Ms. Eagleson advised that two pieces of legislation passed in the last session charging other state agencies to look at the mental health system in different ways for the state. Director Hamos asked that we postpone discussions on mental health until we find out a little bit more about those committees forming and what approaches will be taken so we don't duplicate efforts with this group. Maybe some people from this group would like to be included in those efforts. She wasn't sure of the state agencies forming the workgroups but HFS could forward the web-link to the pieces of this new legislation to the entire body along with a summary from our sister agencies.

Dr. King stated in terms of the question regarding mental health, this is really looking at care for Medicaid beneficiaries. DHS is responsible for community mental health services for the uninsured in addition to individuals that are Medicaid eligible. There is an Illinois Mental Health Planning and Advisory Council (IMHPAC). She stated that she was a member of their planning committee that reviewed the state mental health plan. She advised that there had been many discussions where they would like to have a discussion with Medicaid about mental health services. There have been a lot of changes in what Medicaid covers. There's a

limit on the amount of therapy received without reauthorization. There are changes that impact access and the quality of care that people are receiving.

Chairperson Gordon stated that while many members sincerely care about the mental health access issues, it may be best to take in account that other agencies are working on this. As we learn more, there could be involvement for the MAC committee.

Ms. Ellinger added that the director's point is that right now we have split responsibility and a lot of the medical services received by the Medicaid population are being delivered by DHS' Division of Mental Health (DMH). The legislature has given direction as to how the agencies work together and DMH has a role in that, and HFS understands it is a stakeholder. Ms. Ellinger suggested that the MAC could make a decision that members could participate if stakeholder groups are formed. So instead of independent reviews and discussions, they are integrated and coordinated discussions.

On the topic of health disparities, Dr. King stated that addressing health disparities is part of the national agenda and part of our state health improvement plan, but she doesn't see it articulated as part of HFS's plan. The idea is that people are deliberate, explicit about identifying and looking at inequities in access and utilization of care and discrimination. When we are looking the Public Education Subcommittee a couple years ago, we had UIC doing an analysis of Hispanic uninsured children presumably to look at where you might want to target those efforts since there is a high uninsured rate in some populations. But there is no reporting or follow up to see if whether or not it made any difference. So, the question is how this agency, of my government, makes it clear to me and other people of color that our needs are being addressed.

Ms. Eagleson advised that yes, absolutely promoting better quality in the healthcare system is about ensuring that quality healthcare is available to everyone regardless of race, ethnicity, diagnosis or disease. The question is what we want this committee to look at. We have limited ability with a very small staff and do not have a dedicated staff that can just do research. In what way would you like the committee to focus on that?

Dr. King stated that her concern isn't about this committee, but about HFS. Reading from her memo to Chairperson Gordon, the recommendation is to request HFS implement a policy/practice of identifying racial /ethnic, primary language, and geographic disparities in medical program enrollment, access, utilization and outcomes for HFS beneficiaries. In addition, HFS should publicly report on its efforts to correct identified disparities.

Chairperson Gordon stated that there are two issues. One is a philosophical view of HFS from the top that you're seeking and the other is what are we looking at and how do we get it done.

A motion was offered by Dr. King to recommend that HFS implement a policy/practice of identifying racial/ethnic, primary language, and geographic disparities in medical program enrollment, access, utilization and outcomes for HFS beneficiaries. In addition, she said that HFS should publicly report on its efforts to correct identified disparities. The motion was seconded but tabled right away by Dr. Pont for further discussion about this motion as part of the broader MAC priorities.

Ms. Ellinger commented that this is a huge amount of work as Ms. Eagleson said, but it is certainly a motion that the MAC could pass. The MAC could say we want HFS to pay more attention to healthcare disparities along these dimensions.

Dr. Kirkegaard asked where does HFS actually collect their priorities and articulate them? Is there an HFS plan for the year or a document that lays out what the priorities are and how the resources will be allocated?

Ms. Eagleson answered that HFS does publish an annual report but it is mostly retrospective. A section was added about what we see coming. Connecting resource to priorities is a little more difficult as our budget is appropriated by the general assembly. So the answer is yes and no.

Chairperson Gordon advised that she liked the idea of taking this topic up again at the next meeting. She suggested that members take a look at the resolution and think how members feel about the words on health disparities. We can also allow more time to discuss other priorities that could be movable into a motion.

IX. Review of Subcommittees

Chairperson Gordon stated that she would like to review the charge for each subcommittee. A binder with the subcommittee charges, membership and meeting dates was provided to each MAC member attending in Chicago. She shared that the same information is available on the department's website. The bylaws call for members of the MAC to review subcommittee membership and the charges at the second meeting of the year. We are seeking recommendations from the MAC for membership on the subcommittees.

Ms. Ellinger added that there is very little information in the bylaws that describe how many members should be on the subcommittees or who they should be. The bylaws direct the composition of the MAC, but not the subcommittees.

Chairperson Gordon stated that she had sent a memo to MAC members asking if someone wanted to serve or know of someone that would be interested and to send the name to Ms. Ellinger. The names have been coming in for the Public Education Subcommittee.

Ms. Ellinger suggested that what should be on the agenda for the next meeting is a review of the charges. It would be useful to discuss what the size of the subcommittees should be and move forward and make some decisions about those appointments.

Chairperson Gordon asked that recommendations for subcommittee membership be made by February 3rd.

X. Open to Committee

Ms Eagleson added that when she was reading the four HFS goals, they were from an update on strategic goals the director prepared last year. If Chairperson Gordon would like, HFS could come back with a larger presentation on the goals. Chairperson Gordon agreed and suggested that the document could be sent out to members for review before the next meeting.

XI. Adjournment The meeting was adjourned at 12:00 p.m. The next meeting is scheduled for March 16, 2012.