ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

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Memorandum

DATE: February 26, 2013

TO: Members of the Medicaid Advisory Committee

FROM: Julie Hamos
Director

RE: Medicaid Advisory Committee (MAC) Meeting

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The next meeting of the Medicaid Advisory Committee is scheduled for Friday, March 8, 2013. The meeting will be held via videoconference from 10 a.m. to 12 p.m. Those attending in Springfield will meet at 201 South Grand Avenue East, 3rd floor video-conference Room B. Those attending in Chicago will meet at 401 South Clinton, 1st floor video-conference room.

Attached please find the agenda, draft minutes from the January 11, 2013 meeting, Illinois Medicaid Redetermination Project FAQ, a handout titled "Project Details for Assisting Clients," FY13 Medicaid Pharmacy Program, Health & Quality of Life Measures, Informational Notice Handout, and the document titled "MAC Suggested Agenda Items." As part of the department's ongoing efforts to reduce administrative cost, copies of the material will not be available at the meeting. Participants should plan on bringing their own copies.

The material has also been posted to the Department's Web site at:
http://www.hfs.illinois.gov/mac/news/

If you have any questions, or need to be reached during the meeting, please call 217-782-2570.

MEDICAID ADVISORY COMMITTEE

401 S. Clinton
1st Floor Video Conference Room
Chicago, Illinois
and
201 South Grand Avenue East
3rd Floor Video-conference Room
Springfield, Illinois

March 8, 2013
10 a.m. - 12 p.m.

AGENDA

I. Call to Order

II. Introductions

III. Approval of November 16, 2012 Meeting Minutes

IV. Director's Report

V. IMRP (formerly EEV) Update with website handouts (2)
http://www2.illinois.gov/hfs/MedicalCustomers/eev/Pages/default.aspx

VI. Prior Approval Issues with Prescriptions
   a. FY13 Medicaid Pharmacy Program
   b. Health and Quality of Life Performance Measures
   c. Informational Notice

VII. Subcommittee Reports
   a. Access Subcommittee Report
   b. Long Term Care Subcommittee Report
   c. Public Education Subcommittee Report
   d. Care Coordination Subcommittee Report

VIII. Update on SMART Act 2840

IX. Update on Care Coordination Initiatives
   a. Innovations Project
   b. Dual Medicare/Medicaid Care Integration Financial Model Project
   c. 1115 Waiver Demonstration Project

X. Open to Committee

XI. Adjournment

DRAFT **DRAFT** **DRAFT**

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
Jan Grimes, IHHC
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

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

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 were 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.

Illinois Medicaid Redetermination Project
Frequently Asked Questions (FAQ)

Tenemos información en español. Servicio de intérpretes gratis.

1-855-458-4945 (TTY: 1-855-694-5458)

Will this affect me or my family?

This project will affect most people who get a medical card from the state of Illinois. It includes Medicaid, All Kids Assist, All Kids Share, All Kids Premium Levels 1 and 2, Moms & Babies, FamilyCare, seniors, persons with disabilities; and long term care cases. At least once each year, the state must make sure that you are still eligible for benefits.

What is redetermination?

This is the annual process where the State reviews whether your medical case meets the rules for you to keep getting benefits.

How will I know when it's time for redetermination of my case?

The State will review your case, and only reach out to you if additional information is needed to complete the redetermination. You will not need to complete a redetermination form unless additional information is needed. If we need information from you, you will receive a letter from the State. It will be very important that you provide the information requested. If you live in a nursing home or supported living facility, you will still get an annual redetermination form to complete.

How is redetermination decided?

The redetermination review uses the information you gave on your application, information you may have shared with your caseworker, and other electronic information to check if anything about your case has changed in the time since your benefits were approved. If your case still meets all the rules, your redetermination will be approved and you can still get medical benefits.

How will I know if I can still get medical benefits?

You will get a letter in the mail that tells you whether you still qualify. If your redetermination is approved, the letter will tell you about your benefits. If it is not approved, the letter will tell you why. You may also get a letter that asks you to send more information to help us decide.

If I didn't get a medical card this month, does that mean I have been cancelled?

Probably not. A recent Illinois law mandated that the State stop sending a new Medicaid card each month. In March of 2013, new cards will be sent to all Medicaid clients with a notice that they should not expect to receive a new card until their next redetermination date. Over the next year, all cases will be redetermined by this project. At the time of redetermination, you will either get a notice of continuation or a notice of cancelation. Clients should not expect to receive a new card each month as has happened in the past.

What proof documents may I be asked to send?

We may ask you to send documents that show us proof of your income, resources (assets), home address, Social Security number, other insurance, or how many people live with you.

Where do I send proof documents?

You can send your proof documents one of these ways:

- Fax your proofs to **1-855-394-8066**. This is the fastest and easiest way.
- Mail your proofs to Illinois Medicaid Redetermination, PO Box 1242, Chicago, Illinois 60690-1242.

If we ask you for proof documents, we'll send you a postage-paid envelope to mail the proofs back to us.

Can I take my documents to my local office?

Please call the hot line number (**1-855-458-4945** or TTY: 1-855-694-5458) to determine best place to take documents. You can take to your local office, but the chance of documents getting lost is less if you talk to the hotline to determine the best way to return documents.

I missed the due date to send proof documents. What should I do?

If you did not send the proof documents in time, please call us at **1-855-458-4945** (TTY: 1-855-694-5458) right away. Or, you may talk to your caseworker.

Do I still have a caseworker?

Caseworkers are still available to assist clients and make all eligibility decisions. The Illinois Medicaid Redetermination Project will help caseworkers by collecting necessary information needed to redetermine eligibility.

Can I ask for letters to be sent to me in a language other than English?

If you prefer to receive written information in Spanish call us at **1-855-458-4945** (TTY: 1-855-694-5458). Tenemos información en español. Servicio de intérpretes gratis.

Can you share information about my redetermination with someone who is not in my family?

If you want us to give your information to someone who is not in your family, you must let us know by filling out a form. If you want us to fax or mail you the form, please call us at **1-855-458-4945** (TTY: 1-855-694-5458). The call is free.
After filling out and signing the form, fax it back to us at **1-855-394-8066** or mail it to Illinois Medicaid Redetermination, PO Box 1242, Chicago, Illinois 60690-1242.

How can I check the status of my case?

If you got a letter in the mail from Illinois Medicaid Redetermination Project, you can call us at **1-855-458-4945** (TTY: 1-855-694-5458) on Monday to Friday from 7:00 a.m. to 9:00 p.m. and Saturday from 8:00 a.m. to 1:00 p.m. The call is free!

What if I get medical benefits plus other benefits, such as cash assistance or SNAP (Supplemental Nutrition Assistance Program)?

Your caseworker will complete your redetermination and contact you for any proof documents that are needed. Your caseworker will mail you a letter telling you the decision about your redetermination. If your redetermination is approved, the letter will tell you about your benefits. If it is not approved, the letter will tell you why.

I think the decision about my redetermination is wrong. What can I do?

If you do not agree with a decision about your medical benefits, you should contact your caseworker and discuss the change. You can also appeal the decision and ask for a special process called a fair hearing. You must ask for fair hearing within **60 calendar days** of when the decision was made or the postmark date of the Notice. Please refer to the Notice you received for more information on how to file a fair hearing.

Why did the State begin the Illinois Medicaid Redetermination project (IMRP)?

The primary goal of the Illinois Medicaid Redetermination project is to make sure people who get medical benefits from the state really qualify for them. The project was created by a new law, called the SMART Act. The Public Act number of the new law is IL 97-0689.

Project Details for Assisting Clients

The Departments of Healthcare and Family Services (HFS) and Human Services (DHS) are initiating an enhanced eligibility verification project with the official name of the "Illinois Medicaid Redetermination Project" (IMRP) and the unofficial name of EEV (Enhanced Eligibility Verification). The purpose of this project is to process the backlog of cases that require immediate redeterminations and ensure that going forward, redeterminations will be processed in a timely manner, so that eligibility for Medicaid coverage is verified on an annual basis. This note will provide some background information on the project in case of inquiries from clients or to otherwise answer questions.

Background

The Illinois Medicaid Redetermination Project arose from an emergency procurement authorized by the Save Medicaid Access and Resources Together (SMART) Act of May 2012, to secure services of a Vendor to assist in the verification of income, assets and residence for Medicaid eligibility through use of data matching resources.

On September 13, 2012, the State entered into a contract with MAXIMUS Health Services, Inc., who in turn subcontracted with HMS for the data matching component. This document summarizes the key program components, including:

- Scope of Work;
- Impacted Programs;
- Schedule; and
- Illinois Medicaid Redetermination Program Hotline Information.

Scope of Work

- MAXIMUS will review cases using a proprietary system, developed by HMS, a firm that assembles data from multiple data sources. Using business rules, the system indicates cases that are most likely eligible and those potentially ineligible for medical benefits.
- While some of the data can be verified entirely through electronic means, conflicting and/or missing data will require customer contact.
    - For cases where no benefits other than Medical benefits are involved, MAXIMUS will contact clients who will have 10 business days to supply additional information.
    - When MAXIMUS does contact clients, they will identify themselves as working for the Medicaid Redetermination Project (as opposed to working for MAXIMUS) in order to reduce client confusion; any information or supporting documents returned by clients will be to the Illinois Medicaid Redetermination Project.
    - Where the case includes SNAP or cash assistance, the clients will be contacted by the State Caseworkers using current procedures.
- MAXIMUS Eligibility Specialists will review most medical only cases, and provide recommendations using State-approved Policies and Procedures, and Work Instructions. A few smaller medical programs, such as the Breast and Cervical Cancer Program, Illinois Veterans care, Health Benefits for Workers with Disabilities and Illinois Healthy Women will not be included in the IMRP process.
- The State Caseworkers will determine if the recommendation is correct, and complete the Redetermination in the State's eligibility system. The redetermination processing of medical-only cases will be largely consolidated in some regional centers, the largest of which will be in Chicago. Cases with other benefits will continue to be worked by caseworkers in their local offices as is now the case.
- MAXIMUS will provide clients with access to dedicated customer support and a variety of tools to confirm the status of their case in the eligibility redetermination process and submit required documentation:
    - Illinois Medicaid Redetermination Program Hotline: a call center staffed with Customer Service Representatives specifically trained to handle questions and inquiries concerning the

redetermination process. They will answer the phone as “Medicaid Redetermination Project”.

- There will be multiple channels for submitting documentation: mail and fax, and, subsequently, scanned material.

- State Caseworkers will have access to detailed work instructions, FAQs and other project materials on the DHS and HFS Intranet Sites where recommendations are also recorded.
- Public-facing information about the project will be posted to the DHS and HFS Internet Sites throughout the life of the contract. The information will be supplementary information to assist in the redetermination process.

Impacted Programs

- MAXIMUS will provide a redetermination recommendation for the following programs. Clients within these programs may contact the IMRP Hotline.
  - Aid to the Aged, Blind and Disabled (AABD), including Long Term Care
  - (LTC) Family Health Plans, including:
    - FamilyCare/All Kids
    - Assist All Kids Share
    - All Kids Premium Level 1
    - All Kids Premium Level
    - 2 All Kids Rebate
    - Moms and Babies
- MAXIMUS will **NOT** provide a redetermination recommendation for the following medical programs. Clients within these programs should continue to work with their respective caseworkers or local office.
  - Health Benefits for Workers with
  - Disabilities Veteran’s Care
  - Breast & Cervical Cancer
  - Program Illinois Healthy Women

Clients who have other benefits in addition to Medicaid (primarily Supplemental Nutritional Assistance Program, SNAP, the official name for “food stamps”) should continue to work with their local caseworker.

Schedule

The following schedule outlines key program implementation dates:

Illinois Medicaid Redetermination Program Schedule

Date	Activity
January 2, 2013	MAXIMUS-operated Illinois Medicaid Redetermination Program reviews and assesses initial test cases and addresses issues
February, 2013	Full hotline and recommendation processing for medical-only cases
March 1, 2013	MAXIMUS begins review of cases that also include SNAP or other benefits
February 22, 2013	State begins to receive medical-only case redetermination recommendations

Since the initial case efforts will be focused on cases that have higher probability of being ineligible, there may be a wave of clients losing eligibility, particularly in February through April.

IMRP Hotline Information

A client who has been asked to submit information to the Illinois Medicaid Redetermination Project should submit the data as shown below. Data can also be taken to local DHS office (or sent to the All Kids Unit) but returning directly to the Redetermination Project in the stated time frames will decrease likelihood of recommendations being made for discontinuation due to missing, conflicting or outdated information.

While the project is very focused on maintaining business continuity, the situation of most concern is where a client is required to submit information to the Redetermination Project within 10 business days. When that period has elapsed, the control of the case is returned to the local office (or the All Kids Unit if that's where case was being maintained) for a final decision. Once the case recommendation has been returned to the local office, the client should submit information there—or contact their local office if they are cancelled and they believe the cancellation is in error. Our plan calls for any information that gets to the Call Center to be routed to the local office if they have re-assumed control of the case, but the more hand-offs, the greater the risk of process break-downs. ***Clients will need to pay attention to any deadlines in correspondence and direct responses accordingly***.

Illinois Medicaid Redetermination Program Hotline Information

Hours of Operation:

- Monday – Friday, 7 a.m. – 9 p.m., Central Time
- Saturday, 8 a.m. – 1 p.m., Central Time

Holidays: The IMRP Hotline will be closed on the following holidays:

- New Year's Day
- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving Day
- Christmas Day

Phone Number:

- 1-855-HLTHYIL (1-855-458-
- 4945) TTY 1-855-694-5458
- FAX: 1-855-394-8066

Mailing Address:

- Illinois Medicaid Redetermination, PO Box 1242, Chicago, IL 60690-9992

Email Address:

- HFS.Medredes@illinois.gov

FY13 Medicaid Pharmacy Program

Medicaid Pharmacy Utilization		
	FY12	**FY13 YTD**
Average Scripts/Enrollee	.77	.67
Average Cost/Script	$56	$50
Average Monthly Liability	$117M	$86M
Total Scripts	24M	20.5M (est)
*Brand/Generic Ratio	10%/90%	9%/91%
Brand $/Script	$294	$307
Generic $/Script	$30	$23

*Based on script volume, not spending

Third Party Liability (TPL)/Cost Avoidance

- Implemented Cost Avoidance July 1, 2012
- Average monthly TPL payment increased from $1.5M in FY12 to $2.6M in FY13
- Average monthly # patients w/ TPL reported on a claim increased from 10,000 in FY12 to 17,000
- Average monthly # claims w/ TPL reported increased from 19,000 to 30,000
- FY13 savings projected at $13M based on utilization through December 2012

Prior Approval for Specialty Drugs

- Implemented prior approval for several classes on July 1, 2012 (oncology agents, immunosuppressives, anti-retroviral, EPOs, Hepatitis C, Immune Globulin)
- FY13 savings projected at $19M based on utilization through December 2012

Hemophilia Patient Management

- Implemented Standards of Care Agreement (SOCA) requirement August 1, 2012. Revised SOCA in process.
- Required prior approval for blood factor effective December 1, 2012
- Repriced blood factor based on acquisition cost—projected FY13 savings $2.3M ($5M annual)
- Excluding one outlier patient, will see decrease of $4M in spending on blood factor through prior approval and utilization controls

Four Prescription Review Policy

- Implemented claims processing edit on September 6, 2012 at 10 prescriptions per month
- As of December 5, 2012, review after a patient has filled 7 prescriptions in a month.
- On February 1, 2013, moving to 5 prescriptions per month, and applying the limit to residents of long term care facilities

Operational Improvements

- Added temporary data entry staff. Requests entered within 2 - 3 hours of receipt, typically
- Pharmacists review requests within 30 minutes of data entry, typically
- MEDI system provides more user-friendly response to prescriber; providers can query by RIN—don't need PA request number
- On December 14, 2012, doubled incoming prior approval phone lines from 24 to 48.
- Prior approval pharmacists reaching out to high volume prior approval requestors to provide technical assistance with using MEDI prior auth application.
- MEDI based prior auth requests increased from 300 in September to 2,000 in January.

Program Statistics

- Number of adults w/ > 4 scripts has decreased **41%** since August (194,600 vs. 122,800)
- Number of adults w/ > 10 scripts has decreased **80%** since August (7,000 vs. 1,400)
- Number of beneficiaries "Hitting" claims processing edit since inception (YTD): **42,000**
- Total Four Script Override Prior Auth Requests YTD: **133,000** (84,000 approvals/49,000 denials) *(as point of reference – we do about 360,000 prior approval requests per year non script limit)*
- Have identified & implemented **11** additional duplicate therapy claims processing edits based on issues identified through script limit medication reviews (list on HFS website)

Provider Education

- Have created **2** educational documents based on common prescribing problems encountered in the review process—posted to website. Additional educational documents in process.
- Exploring possibility of providing CE for providers who review our educational pieces

Specific Cases

Example #1: 48 yr old woman

Problem: Duplicate Therapy - Multiple Narcotics

On 3 long acting narcotics and 1 short acting narcotic together for pain control.

- Pharmacist contacted doctor to discuss pain management.
- Since the long-acting agents are duplicate therapy, doctor agreed to d/c oxycontin prescription.
- Reduced annual expenditure of $4,255.
- Reduced the risk of side effects from this narcotic combination.

Example #2: 57 year old woman with Chronic Obstructive Lung Disease (COPD)

Problem: Duplicate Therapy and Poor Compliance

- Filling 6 different drugs for COPD
- Patient not filling prescriptions routinely, leading to worsening of her disease.
- Pharmacist contacted the doctor to discuss the case. Doctor thought patient was compliant and had added additional drugs. Doctor agreed to stop 2 drugs and address compliance with patient. Doctor was thankful for the information.
- Reduced annual expenditure of $2,700.
- Improved compliance will reduce exacerbations of her lung disease and improve patient's health

Example #3: 55 yr old woman with coronary artery disease

Problem: Serious Drug Interaction

- Patient filling heartburn medicine with a medicine to prevent blood clots and stroke.
- Using these together reduces the efficacy of blood clot/stroke medication which could lead to the formation of life-threatening clots
- Pharmacist contacted doctor who was thankful for intervention and changed heartburn medication.
- Minimal reduction in drug expenditure, but potential prevention of heart attack or stroke.

Example #4: 27 yr old woman with high blood pressure

Problem: Duplicate therapy

- Patient filling 2 drugs from same class for blood pressure.
- Pharmacist contacted the doctor to discuss case. Doctor had intended that patient d/c 1st drug, and thought patient was only taking 2nd drug. Pharmacy was filling both agents. Doctor agreed to stop 1 of the drugs. The pharmacy was contacted to stop the 1st medication.
- Reduced annual expenditure of $1,812.

- Potentially avoided serious side effects including very low blood pressure and kidney damage.

Health and Quality of Life Performance Measures: Adults and Seniors with Disabilities

#	Performance Measure	Further Description	Specification Source	Data Source	Population Reported *
Access/Utilization of Care					
1	**Access to Members Assigned PCP (AMP)**	Percentage of members who had an ambulatory or preventive care visit with the members assigned PCP during the measurement year.	State	Claims/ Encounter	All, Aging & PD
2	**Ambulatory Care (AMB)**	Emergency Department visits per 1,000 Enrollees	HEDIS®	Claims/ Encounter	All, Aging, PD & DD
3	**Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit (APE)**	Follow-up with any Provider within 14 days following Emergency Department visit	State	Claims/ Encounter	All, Aging & PD
4	**Inpatient Utilization General Hospital/Acute Care (IPU)**	Utilization of acute inpatient care and services, per 1,000 Enrollees, in the following categories: Total inpatient, Surgery, Medicine and Maternity.	HEDIS®	Claims/ Encounter	All, Aging & PD
5	**Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge (API)**	Ambulatory care follow-up visit within 14 days of having an inpatient hospital stay.	State	Claims/ Encounter	All, Aging & PD
6	**Inpatient Hospital 30-Day Readmission Rate**	Inpatient Hospital readmission for the same discharge diagnosis within 30 days after having an initial inpatient hospital stay.			
	1) Acute inpatient facility (IHR)		State	Claims/ Encounter	All, Aging & PD
	2) Inpatient mental hospital (IMR)		State	Claims/ Encounter	All & PD
Preventive/Screening Services					
7	**Care Coordination Influenza Immunization Rate (CCI)**	Percentage of members 19 years and older who received at least one influenza immunization during the measurement year.	State	Claims/ Encounter	All, Aging, PD & DD
8	**Colorectal Cancer Screening (COL)**	Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	HEDIS®	Claims/ Encounter	All & Aging
9	**Breast Cancer Screening (BCS)**	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	HEDIS®	Claims/ Encounter	All, Aging & PD

* All = Total ICP population, Aging = Aging Waiver Members, PD = Physically disabled, TBI and HIV/AIDS waiver members, DD = Developmentally disabled waiver members

Health and Quality of Life Performance Measures: Adults and Seniors with Disabilities

#	Performance Measure	Further Description	Specification Source	Data Source	Population Reported *
10	**Cervical Cancer Screening (CCS)**	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	HEDIS®	Claims/ Encounter	All & PD
11	**Adult BMI Assessment (ABA)**	Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.	HEDIS®	Claims/ Encounter	All & PD
12	**Glaucoma Screening in Older Adults (GSO)**	Percentage of members age 40 – 59, 60 – 64, 65 years and older and Total who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions.	State	Claims/ Encounter	All & Aging
		Dental			
13	**Annual Dental Visit (ADV)**	Percentage of members 19-20, and 21 years of age and older who had at least one dental visit during the measurement year.	State	Claims/ Encounter	All, PD & DD
14	**Dental ER Visit (DERV)**	The number of dental emergency room visits during the measurement year per 1,000 members.	State	Claims/ Encounter	All & PD
		Appropriate Care			
15	**Annual Monitoring for Patients on Persistent Medications (MPM)**	Percentage of members who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the agent during the measurement year. Report on each of the following rates: ACE/ARB, Digoxin, Diuretics, Anticonvulsants and Total.	HEDIS®	Claims/ Encounter	All, Aging & PD
16	**Use of High-Risk Medications in the Elderly (DAE)**	Assesses the percentage of member's age ≥60 who received at least one drug to be avoided in the elderly and the percentage of members who received at least two different drugs to be avoided in the elderly. A lower rate represents better performance	State	Claims/ Encounter	All & Aging
17	**Comprehensive Diabetes Care**	The percentage of members 18-75 years of age with			

* All = Total ICP population, Aging = Aging Waiver Members, PD = Physically disabled, TBI and HIV/AIDS waiver members, DD = Developmentally disabled waiver members

Health and Quality of Life Performance Measures: Adults and Seniors with Disabilities

#	Performance Measure	Further Description	Specification Source	Data Source	Population Reported *
	(CDC)	diabetes (type 1 and type 2) who had each of the following.			
	1) Hemoglobin A1c (HbA1c) testing	An HbA1c test performed during the measurement year.	HEDIS®	Claims/ Encounter	All, Aging, PD & DD
	2) Medical attention for nephropathy	A Nephropathy screening or evidence of nephropathy.	HEDIS®	Claims/ Encounter	All, Aging & PD
	3) LDL-C screening	An LDL-C test performed during the measurement year.	HEDIS®	Claims/ Encounter	All, Aging & PD
	4) Statin Therapy	Statin Therapy 80% of the time	State	Claims/ Encounter	All, Aging & PD
	5) ACE/ARB Therapy	ACE/ARB 80% of the time	State	Claims/ Encounter	All, Aging & PD
18	**Congestive Heart Failure (CHF)**	Percentage of members with congestive heart failure (CHF) who had the following:			
	1) ACE/ARB 80% of the time		State	Claims/ Encounter	All & Aging
	2) Beta Blocker 80% of the time		State	Claims/ Encounter	All & Aging
	3) Diuretic 80% of the time		State	Claims/ Encounter	All & Aging
19	**Coronary Artery Disease (CAD)**	The percentage of members with coronary artery disease (CAD) who had the following:			
	1) Cholesterol testing	Members with CAD who had cholesterol tested at least once during the measurement year.	HEDIS®	Claims/ Encounter	All & Aging
	2) Statin Therapy 80% of the Time		State	Claims/ Encounter	All & Aging
	3) ACE/ARB Therapy 80% of the Time		State	Claims/ Encounter	All & Aging
	4) Persistence of Beta-Blocker Treatment After a Heart Attack	The percentage of members 19 years of age and older during the measurement year who were	HEDIS®	Claims/ Encounter	All & Aging

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Health and Quality of Life Performance Measures: Adults and Seniors with Disabilities

#	Performance Measure	Further Description	Specification Source	Data Source	Population Reported *
	(PBH)	hospitalized with AMI and who received persistent beta-blocker treatment for six months after discharge.			
20	**Pharmacotherapy Management of COPD Exacerbation (PCE)**	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter and who were dispensed appropriate medications.			
	1) Dispensed a systemic corticosteroid within 14 days of the event		HEDIS®	Claims/ Encounter	All, Aging & PD
	2) Dispensed a bronchodilator within 30 days of the event		HEDIS®	Claims/ Encounter	All, Aging & PD
	3) Use of Spirometry testing in the Assessment and Diagnosis of COPD (SPR)	The percentage of members 40 years old or older with a new diagnosis or newly active COPD, and who received appropriate Spirometry testing to confirm the diagnosis.	HEDIS®	Claims/ Encounter	All, Aging & PD
Long Term Care					
21	**Long Term Care – Urinary Tract Infection Admission Rate (UTI)**	LTC hospital utilization due to urinary tract infections	State	Claims/ Encounter	LTC
22	**Long Term Care – Bacterial Pneumonia Admission Rate (BPR)**	LTC hospital utilization due to bacterial pneumonia.	State	Claims/ Encounter	LTC
23	**Long Term Care Residents – Prevalence of Pressure Ulcers (PPU)**	LTC Residents that have category/ stage II or greater pressure ulcers.	State	Claims/ Encounter	LTC
Behavioral Health					
24	**Antidepressant Medication Management (AMM)**	Percentage of members diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication for ***Effective Acute Phase Treatment*** - At least 84 days continuous treatment with antidepressant medication during 114 day period following Index Prescription Start Date (IPSD)	HEDIS®	Claims/ Encounter	All & PD

* All = Total ICP population, Aging = Aging Waiver Members, PD = Physically disabled, TBI and HIV/AIDS waiver members, DD = Developmentally disabled waiver members

Health and Quality of Life Performance Measures: Adults and Seniors with Disabilities

#	Performance Measure	Further Description	Specification Source	Data Source	Population Reported *
25	**Antidepressant Medication Management (AMM)**	Percentage of members diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication for ***Effective Continuation Phase Treatment*** - At least 180 days continuous treatment with antidepressant medication during 231 day period following Index Prescription Start Date (IPSD).	HEDIS®	Claims/ Encounter	All & PD
26	**Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)**	Percentage of member's age 19 – 64 years with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	HEDIS®	Claims/ Encounter	All & PD
27	**Adherence to Appropriate Medications for Individuals Diagnosed with Psychoses and Bi-Polar Disorders (PBD)**	Percentage of members diagnosed with psychoses and bi-polar disorders who maintained medication adherence at 6 months and 12 months.	State	Claims/ Encounter	All & PD
28	**Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)**	Percentage of members with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.	HEDIS®	Claims/ Encounter	All & PD
29	**Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)**	Percentage of members with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	HEDIS®	Claims/ Encounter	All & PD
30	**Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)**	Percentage of members with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	HEDIS®	Claims/ Encounter	All & PD
31	**Behavioral Health Risk Assessment and Follow-up (BHRA)**	Percentage of new members who completed a behavioral health assessment (BHRA) within 60 days of enrollment. Also measures percent of Enrollees with a positive finding on BHRA who receive follow-up with MH provider within 30 days of assessment			

* All = Total ICP population, Aging = Aging Waiver Members, PD = Physically disabled, TBI and HIV/AIDS waiver members, DD = Developmentally disabled waiver members

Health and Quality of Life Performance Measures: Adults and Seniors with Disabilities

#	Performance Measure	Further Description	Specification Source	Data Source	Population Reported *
	1) Behavioral Screening/ Assessment within 60 days of enrollment		State	MCO	All, Aging & PD
	2) Behavior Health follow-up within 30 days of screening		State	MCO	All, Aging & PD
32	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**	Members with a new episode of alcohol or other drug (AOD) dependence who received initiation and engagement of AOD treatment.	HEDIS®	Claims/ Encounter	All & PD
33	**Follow-up with a Provider within 30 Days after an Initial Behavioral Health Diagnosis (FUP)**	Determines if a member had timely follow-up with a Practitioner following their initial behavioral health diagnosis.	State	Claims/ Encounter	All, Aging & PD
34	**Follow-Up After Hospitalization for Mental Illness (FUH)**	The percentage of discharges for members 19 years and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.			
	1) Follow-up within 7 days of discharge		HEDIS®	Claims/ Encounter	All, Aging & PD
	2) Follow-up within 30 days of discharge		HEDIS®	Claims/ Encounter	All, Aging & PD
35	**Mental Health Utilization (MPT)**	Percentage of members receiving the following mental health services during the measurement year, per 1,000 Enrollees: Any service, Inpatient, Outpatient or ED, and Intensive outpatient or partial hospitalization.	HEDIS®	Claims/ Encounter	All, Aging & PD
36	**Severe Mental Illness (SMI)**	Recovery-oriented measures for persons with SMI receiving MH services			
	1) Stability in Family and Living Conditions		State	DHS/ Provider	All & PD
	2) Return or Stay in School		State	DHS/ Provider	All & PD

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Health and Quality of Life Performance Measures: Adults and Seniors with Disabilities

#	Performance Measure	Further Description	Specification Source	Data Source	Population Reported *
	3) Criminal/Juvenile Justice Involvement		State	DHS/ Provider	All & PD
	4) Employment Status		State	DHS/ Provider	All & PD
Waiver Utilization					
37	**Movement of Members between Community, Waiver and LTC Services (MWS)**	Report number of members moving from: institutional care to waiver services, community to waiver services community to institutional care and waiver services to institutional care. (Exclude institutional stays ≤ 90 days)	State	MCO/HFS	All, Aging, PD & SLF
Surveys					
38	**CAHPS – Consumer Assessment of Health Plan Survey (CPA)**	CAHPS, Adult Version as approved by HFS. Provides information on the experiences of members with the organization and gives a general indication of how well the organization meets member's expectations.	State	MCO Survey	All, Aging, PD & DD
39	**Fall Risk Management (FRM)**	The percentage of Medicaid members 60 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner	State	MCO/ Survey	All, Aging
40	**Management of Urinary Incontinence in Older Adults (MUI)**	*Discussing:* Members who reported having a problem with urine leakage in the past six months and who discussed their urine leakage problem with their current practitioner. *Receiving Treatment:* Members who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem.	State	MCO/ Survey	All, Aging
41	**Physical Activity in Older Adults (PAO)**	*Discussing Physical Activity:* Members who had a doctor's visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity. *Advising Physical Activity:* Members who had a doctor's visit in the past 12 months and who received advice to start, increase	State	MCO/ Survey	All, Aging

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Health and Quality of Life Performance Measures: Adults and Seniors with Disabilities

#	Performance Measure	Further Description	Specification Source	Data Source	Population Reported *
		or maintain their level exercise or physical activity.			
42	**Aspirin Use and Discussion (ASP)**	***Aspirin Use***. A rolling average represents the percentage of members who are currently taking aspirin. Includes the following in the denominator: Women ages 55-79 with at least 2 risk factors for heart disease, Men ages 45-64 with at least one risk factor for heart disease and Men ages 65-79 regardless of risk factors. ***Discussing Aspirin Risks and Benefits***. A rolling average represents the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. Includes the following in the denominator: Women ages 55-79 and men ages 45-79.	State	MCO/ Survey	All, Aging
43	**Participant Outcomes and Status Measures (POSM) Quality of Life Survey**	Program participant perception of quality of life. Purposes: 1) help determine quality of life measures that should be considered in developing service plans; 2) determine if quality of life improvements are reported by participants over time; and, 3) assist in identifying areas in need of quality improvement.	State	MCO/ Survey	Aging

* All = Total ICP population, Aging = Aging Waiver Members, PD = Physically disabled, TBI and HIV/AIDS waiver members, DD = Developmentally disabled waiver members

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
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Informational Notice

Date: October 26, 2012

To: Participating Advanced Practice Nurses, Dentists, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Encounter Rate Clinics (ERCs), Hospitals, Local Health Departments, Pharmacies, Physicians, Podiatrists and School Based/Linked Health Centers

Re: Four Prescription Policy

The Medicaid reform law, called the *SMART Act (pdf)*, signed into law in June 2012, requires the department to require prior approval for medications after a client has filled four prescriptions in the preceding 30 days. This statutory requirement applies to both adults and children. This notice provides updated information on the policy including general information and information related to resolution of implementation challenges.

Policy Background and General Information

The purpose of the four prescription policy is to have providers review their patients' entire profile of maintenance medications and, where possible and clinically appropriate, reduce duplication, unnecessary medications, and poly-pharmacy, and avoid other problems. The four prescription policy was developed as a result of budget negotiations, but best-practices call for an annual review of the full regimen of prescriptions for any patient.

Exclusions: Drugs in the following classes will not require prior approval as a result of the four prescription policy: Oncology Agents; Anti-Retroviral Agents; Contraceptives; and Immunosuppressives. In addition, over-the-counter drugs and non-drug items such as blood glucose test strips and monitors are excluded from the policy.

Exceptions: The four prescription policy is not a "hard" limit. Medicaid patients can and should have access to medications that are medically necessary, even if they exceed four prescriptions per 30 days. The policy simply requires prior approval (PA) for prescriptions above four, for the purpose set forth above.

Emergency Situations: When department staff is not available to process PA requests (during non-business hours such as evenings or weekends) in an emergency situation, a pharmacy can dispense a 72-hour supply, and will be reimbursed after the pharmacy follows up with a prior approval request for the emergency supply.

Phase-In: In order to ensure that the PA volume does not exceed the department's data entry and review capacity, we are phasing in the implementation. In July, we began reviewing the highest users – those with more than 12 prescriptions per month. We are now moving down steadily toward the required standard. Currently, we require prior approval for a patient's prescriptions after the patient has filled nine prescriptions in the preceding 30 day period. In addition, currently, prescriptions for children under the age of 19 will not reject as a result of the policy. Also, currently, prescriptions for clients residing in long-term care facilities will not reject as long as their admission to the facility is properly recorded in the department's eligibility system. The department will continue to phase in the implementation based on capacity.

Prior Approval Timeframes: In general, a four prescription policy override request is approved for one year. In certain circumstances short-term approvals will be granted and the provider will be notified by department staff. An example would be in a circumstance where a provider was unaware a patient was taking a medication that cannot be stopped abruptly and requires tapering.

Prior Approval Methods: Prescribers can request PA in three ways:

- Calling the prior approval hotline
- Faxing a PA request to the PA hotline
- Requesting PA through MEDI (online application)

The MEDI online PA application is encouraged, and is discussed in more detail below.

Implementation Challenges and Resolutions

With 2.7 million clients, we recognize that the volume of PA requests and resulting delays are creating problems for providers, pharmacies, and clients. We are taking the following steps to address outstanding issues:

Delay in Data Entry of Faxed Requests: We have hired and trained temporary employees to assist with data entry, and as of October 24, 2012, data is generally being entered within approximately four (4) hours of receipt of request.

Clinical Review: The department significantly increased the number of pharmacists available to conduct PA reviews. Our clinicians currently are reviewing and making determinations on four prescription policy overrides within about two (2) hours of data entry.

Prior Authorization Hotline Availability: The Prior Authorization hotline is receiving significantly more calls than usual, resulting in long hold times and busy signals. The department is establishing an overflow line. The overflow line will not place providers in the hotline queue to be answered but will provide a recorded message about MEDI (more information on MEDI below) and will refer the provider to other avenues to check the status of a request already made.

Notification of Determination on Prior Approval Requests: Many calls to the hotline are simply to check the status of a prior authorization request that has already been made. **Please do not call the hotline to check the status of a four prescription policy override PA request.** Following are alternative methods of checking the status of a request.

- **Web-Based Inquiry.** Providers can request notification of a determination on a prescription policy prior authorization request by submitting a status inquiry on the department's Web site. Department staff will respond with the status of the request(s) that provider has made on behalf of the patient.
- **MEDI.** If you use the Medical Electronic Data Interchange (MEDI) system to enter a prior approval request, you can check the status of the request through the MEDI system using the prior approval request number.
- The department continues to explore other alternative methods of checking the status of a prior approval request.

Pharmacist Involvement in Process: The department believes that in order for the four prescription policy to be meaningful, a provider must review the patient's entire medication profile and determine those medications that are necessary and appropriate. Currently, the department requires the prescriber to request overrides. The department is exploring ways to involve the pharmacists in the prior approval process.

Promotion of the Web-Based PA System: Prescribers are **strongly** encouraged to use the MEDI PA system for prior approval requests. Requests entered into the MEDI system **go directly into the department's drug prior approval adjudication database for review by a physician or pharmacist**. Requests that are faxed to the department's Prior Approval Hotline must be data entered after receipt. The MEDI system is a more streamlined process and reduces the calls to the Hotline, and the amount of data entry that has to be performed by hotline staff. Providers who wish to use the MEDI System will need to complete the registration process if they have not already.

MEDI PA System Improvements—We Are Listening: The department is improving MEDI to better serve providers and make the PA system more efficient. Improvements expected to be implemented soon include:

- Providers will be able to query prior approval status by Provider NPI and RIN, and will receive status of all of their requests for that patient for the prior three months.
- The response to the status check query will contain additional information, including the drug name, the date range of the approval if applicable, and the denial reason if applicable.
- There will be a "form" specifically designed for four prescription policy override requests that is tailored to this policy.

Increasing MEDI PA System Awareness: We have identified high volume providers who generate a significant number of prior approval requests. Department staff is contacting those providers to help them use the MEDI system to request drug prior approval and four prescription policy overrides and to help them trouble-shoot any issues they encounter with MEDI. We will continue to increase our efforts to educate providers about the system and to encourage its use.

Frequently Asked Questions (FAQs): The department will soon publish a listing of Frequently Asked Questions (FAQs) related to the four prescription policy. Providers will receive notification when it is available on our Web site.

The Four Prescription Policy Works - We are Seeing Results

While the department acknowledges that there have been some implementation issues, the department also wants to ensure that the provider community knows that we are seeing positive results. Common problem areas identified through PA review include:

- Duplication of therapy, sometimes resulting from multiple prescribers, or from continuation of a prior drug after a prescriber intended to switch the patient to a different drug for the same indication.
- Excessive dosing
- Drug-drug interactions

The department sincerely apologizes for any inconvenience caused our providers as the high volume of PA requests, mandated by the new law, is being managed. We are working hard to make this an efficient, expedited, and effective system to benefit our Medicaid clients. We are also very interested in feedback from the provider community on ways to making the process more efficient. Your feedback is imperative to our ability to develop meaningful solutions that truly improve the process.

Theresa A. Eagleson, Administrator
Division of Medical Programs

MAC Suggested Agenda Items

1. *HIE /OHIT / Metro Chicago Health Clinic* – Topic comes from MAC Care Coordination Committee. Dr. Pont and Jim Parker suggested MAC might be a better forum for this topic. This item was not motioned.
    a. HIE – Two issues: Payments & Exchange; Recommended speaker is Jeff Todd from HFS.
    b. Metro Chicago Health Clinic (MCHC) & OHIT – suggested speaker Laura Zaremba who is the head of OHIT; governor's office. If she comes we will go on her recommendation on whether or not we need an additional speaker from MCHC.
2. *Birth Outcomes* – Issue was raised by Dr. Judy King at the 11/16/12 MAC Meeting (p.8). "She raised concern that there has been little progress regarding HEDIS measures for the frequency of visits for ongoing prenatal and postpartum care". This item was not motioned.
    a. 1/17/13- email/talking point: Illinois was one in five states selected in Kellogg Foundation project – *Optimizing Health Reform to Strengthen Preconception Health and Improve Birth Outcomes.*
3. *PCCM Review and External Quality Reporting* – Following up from a member suggestion at the 9/21/12 meeting. "Review of the PCCM Program and external reports for all voluntary managed care plans. Include looking at the measures for the individual voluntary managed care plans". This item was not motioned.
    a. Illinois Health Connect Handout
4. Co-Pay carry over discussion (added to DRAFT agenda for 3/8/13)
    a. Provider education material
        i. Should be sent out re: not fraud if not collected; how communication is sent to them re: PA process.
5. Flu – 1/11/13: Judy King asked how the department is responding to what is going on with the flu