Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
March 16, 2012

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

Members Present
Susan Hayes Gordon, Chairperson
Kathy Chan, IMCHC
Eli Pick, Post Acute Innovations
Judy King, M.D.
Mary Driscoll, DPH
Linda Shapiro, ACHN
Karen Moredock, DCFS
John Shlofrock, Barton Mgt.

Members Absent
Edward Pont, M.D., ICAAP
Glendean Sisk, DHS
Sue Vega, Alivio Medical Center
Andrea Kovach, Shriver Center
Renee Poole, M.D. IAFP
Jan Grimes, IHHC

HFS Staff
Julie Hamos
Theresa Eagleson
James Parker
Jacqui Ellinger
Lynne Thomas
Robyn Nardone
Sally Becherer
Greg Wilson
Jaci Vaughn
Ann Lattig
James Monk

Interested Parties
Lindsey Artola, Presence Health
Victoria Bigelow, Access to Care
Dave Bilbrey, Meridian
Julie Billingsley, Magellan
Peter Blake, Merdian
John Bullard, Amgen
Kim Call, Biogen Idec
Kelly Carter, IPHCA
Joe Cini, AHS
Laurie Cohen, Civic Federation
Gerri Clark, DSCC
Diane Fager, CPS
Andrew Fairgrieve, HMA
Gary Fitzgerald, Harmony
Kathy Franklin, Access to Care
Pat Gallagher, ISMS
Susan Greene, SGA – HFS
Ann Marie Grimberg, HHO
Marvin Hazelwood, Consultant

Interested Parties
Joe Holler, IHA
George Hovanec, Consultant
Teresa Hursey, Aetna Better Health
Nadeen Israel, Heartland Alliance
Glenn Johnston, GSK
Emilie Junge, Doctors Council SEIU
Esther Jzoyville, FHN
Nicole Kazee, U of I Health Systems
Margaret Kirkegaard, M.D., IHC
Keith Kudla, FHN
Mike Lafond, Abbott
Dawn Lease, Johnson & Johnson
Dennis Majeskie, Johnson & Johnson
Randall Mark, CCHHS
Mona Martin, Vantus
D. R. McCale, Ipsen
Susan Melczer, MCHC
Diane Montañez, Alivio Medical Center
Caitlin Padula, Shriver Center
John Peller, AIDS FDN of Chicago
Susan Reyna, Beacon Therapeutic
Camille Rodriguez, IARF
Phyllis Russell, ACMHAI
Maria Shabanova, Maximus
Amber Smock, Access Living
Janna Stansell, HMPRG
Chester Stroyny, APS Healthcare
Mayumi Tukui, U Chicago Medicine
Peggy Velasquez, ICIRR
Jason Versaysk, Ipsen
Dave Vinkler, AARP
Jessica Williams, CPS – CFBU
Julie Youngquist, Lawrence Hall

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I. Call to Order

Chairperson Gordon called the meeting to order at 10:07 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Approval of January 20, 2012 Meeting Minutes

Dr. King requested a correction on page 10, to read:

> "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."

The minutes were approved with this correction.

IV. Director's Report

HFS Director Julie Hamos thanked Eli Pick for his work as MAC chairman recognizing his commitment and assistance in thinking through how to make the MAC an effective and involved group. She presented him with a certification of appreciation for his valuable years of service. Chairperson Gordon also presented a token of thanks from members of the MAC.

Director Hamos stated that HFS has been put in a very painful position of having to come up with spending and liability reductions totaling $2.7 billion. She wanted people to understand how real this crisis is. She hopes the cuts will be coupled with new revenues. However, legislators are not talking about new revenues. What brought HFS to this point is that for this fiscal year, the department was deliberately underfunded by almost $2 billion. This happened at about the same time that the enhanced federal match that HFS was getting for the last few years ended. At the end of this fiscal year, HFS will have about $1.8 billion in unpaid bills.

The Civic Federation used the department's budget numbers and created a 5-year plan which projected if the state didn't make recommended changes, there would be $22 billion in unpaid bills. Looking out 15 months by the end of the next fiscal year, the department will have $4.7 billion in bills on hand meaning that we will not be able to pay our vendors for a year. This undermines our ability to keep vendors and serve Medicaid clients.

HFS has been asked to put all potential eligibility cuts on the table with three program categories of reductions to look at. These include: 1) reducing eligibility for children from 300 percent to 200 percent of the Federal Poverty Level (FPL), which would impact only 19,000 out of the 1.7 million children enrolled; 2) reducing eligibility for family members enrolled in FamilyCare from 185 percent to 133 percent of the FPL, and; 3) reducing eligibility for state-only funded programs.

There is also a category of cuts called optional services, which are defined as services that the federal government doesn't require states to cover. Although referred to as optional, they were put in place to have less costly and more effective service. Prescription drug coverage for adults is an example of an optional service on the table to completely eliminate which represents savings of about $800 million. If all adult optional services were eliminated, the projected savings would be $1.9 billion. HFS hasn't identified any reductions in services for children.

Director Hamos stated that later today her team will present to the co-chairs of the legislature's Advisory Committee on Medicaid some utilization controls that might produce some additional savings.

HFS hasn't yet had the benefit of a public response. The director believes that providers and community advocates will suggest that HFS shouldn't make these cuts and would try to hold on to their piece of the Medicaid budget. It is difficult to imagine how the department could come up with $2.7 billion in cuts. The legislature would need to vote for some cuts and others may be done by rule changes. The director encouraged members to provide constructive feedback on cuts.

Chairperson Gordon and George Hovanec stated that the IHA and Children's Memorial Hospital have made recommendations to HFS related to cuts. Mr. Hovanec commented that recommendations have been made relating to eligibility controls and concerns with the passive rede process, the impact DHS' understaffing has on keeping people on the rolls too long, and also some potential savings in third party liability payments. Director Hamos indicated that she was not aware of these and would review the recommendations with staff.

Director Hamos noted the department's efforts and challenges, including the Maintenance of Effort requirements under the Affordable Care Act (ACA), to implement the state's Medicaid reform legislation and working with the federal CMS and state interagency agreements.

Diane Fager expressed concern that families with mixed citizenship status are now less likely to access programs and services because they are afraid to apply for Medicaid, as well as state-only funded programs.

Director Hamos advised that HFS covers about 50,000 undocumented children and spends about $52 million in general revenue funds to cover them. There are no federal matching funds. The director indicated that she had tried at the last meeting of the Advisory Committee on Medicaid to take this cut off the table, but didn't succeed.

V. Update on Innovations Project

Status of Solicitation
Director Hamos reported that February 29th was the deadline to submit Letters of Intent to participate in the Innovations Project for adults. About 70 letters were received. Some of these were duplicates and some didn't fit with what HFS is trying to do, but still this was a strong response. Sofia Newman is working with our data-mart and has set up six conference calls with six groups to discuss their data needs. The solicitation for coordinated care for children with complex health needs should be released in April or May this year.

Dual Medicare/Medicaid Care Integration Financial Model Project
There will also be a solicitation with CMS for dual eligibles coverage. The draft RFP is currently open for comment. HFS has identified two regions of the state to serve dual eligibles and may also include non-dual-eligible Medicaid seniors and people with disabilities (SPD) as part of the project. The program will include 150,000 to 200,000 persons in managed care.

VI. Proposed 1115 Waiver Demonstration Project to Cover the Uninsured – Cook County

Theresa Eagleson referred the group to the handout, *1115 Waiver Concept Paper - Cook County Health & Hospitals Systems*, (Attachment 1). She noted people may be aware of this waiver request as the information had been published in newspapers around the state. Given the unique way Illinois finances Medicaid health care services between the county and the state, where Cook County contributes half the resources to pay for the cost of care and as a provider has the single largest uninsured population served in Illinois, HFS was looking for a way to help the county prepare for both better care coordination in and amongst their facilities and with a broader group of providers, as well as bring in the federal money that will be allowed after 2014 to cover this uninsured population earlier.

HFS has proposed to the federal CMS an early expansion for uninsured people up to 133 percent of the FPL. The expansion would be financed only with the local county share and the federal dollars. The plan focuses on patient centered medical homes and gives the county and state a head-start in looking at this population prior to 2014. Ms. Eagleson asked Randall Mark, of the Cook County Health & Hospitals Systems (CCHHS), if he wanted to add to her report or otherwise open the floor to questions.

Mr. Mark thanked the director and her staff for all their work that had started in 2010. It was inspired, in part, by what Cook County had observed in California where public hospitals were seeking a waiver that was ultimately granted and will bring about $600 million a year to California over the next 5 years. In consultation with HFS, CCHHS developed a proposal for a more stream-lined coverage expansion that gives the opportunity to build the care coordination infrastructure comporting with the aims of the Illinois' Medicaid Reform law and federal ACA.

Director Hamos added that since this is an eligibility expansion and because the Medicaid reform legislation required a moratorium on eligibility expansion, state legislative authorization would be required.

The following clarifications on the waiver demonstration were given by HFS.

1) A public notice is required for a waiver request. There is a 30 day period for written comments that ends on April 6th. Comments may be submitted on-line at: http://www2.illinois.gov/hfs/PublicInvolvement/PublicNotices/Pages/ShareYourComments.aspx
2) Although the waiver would decrease the magnitude of the problem with declining federal Disproportionate Share Hospital (DSH) payments, the problem doesn't go away. Cook County's uncompensated care is about three times the amount it receives in DSH funds.
3) The state is not handling any of the redesign of the Cook County system. It has not been determined if payments to Cook will be on a per member per month (PMPM) basis or a fee-for-service reconciliation. From an operational perspective, the state is not reimbursing the county for any of the set-up.
4) For the network, CCHHS expects to partner with other providers for the full range of services for this population. CCHHS anticipates reimbursing those providers directly.
5) Demonstration waivers are generally for five years but implementation of the ACA in 2014 means we may have to transition the waiver to a Medicaid plan in less than 5 years.

Nadeen Israel advised that Heartland Alliance is very supportive of the CCHHS waiver. She stated that her organization encourages the County to coordinate with regional providers, especially in areas of the County where there isn't sufficient access to primary care, mental health and substance abuse services. She also encouraged partnering with providers serving the AABD population.

Amber Smock, of Access Living, stated that many states are pursing similar 1115 waivers. The New Jersey and New Hampshire waivers will cover disability services. There is concern that the Cook County proposal doesn't include long term care, personal care or home health services. A comprehensive medical home should include these components as well as mental health and behavioral health services. Access Living supports the waiver and commends the state for acting on this now. However, further dialogue is needed. She offered to share policy papers on managed care principles for disability services from the National Council on Disabilities and testimony from Texas disability advocates on their state's 1115 waiver proposal.

John Peller, of the Aids Foundation of Chicago, provided a summary of written comments submitted, including a fact sheet outlining possible interactions between the waiver and Ryan White funded services. He stated that there is a HIV funding crisis with a proposed $4 million cut for next fiscal year resulting in a 50 percent cut in community based HIV programs including prevention. His organization believes there is an opportunity for some medication costs to be picked up by the federal government. There is also a concern that the Ryan White program which provides funding for uninsured HIV persons has very strict "payer of last resort" requirements. HRSA says these requirements can't be waived. In California, these requirements were disastrous in their 1115 waiver. Good coordination is needed in the Medicaid and Ryan White programs, so there's no interruption in care.

Emilie Junge, from Doctors Council SEIU, also submitted written comments. She stated that the council, along with SEIU Local 71, represents the bulk of the county employees. She stated that the union is fully supportive of the new care coordination patient-centered model and is working with leadership to make sure it is successful.

Eli Pick commented on the administrative burden created with "payer of last resort" where the denial of a claim is needed so that the payer of last resort will in fact pay. This should be taken into account so that if a bill is not covered under Medicaid it can be presented timely to the last resort payer.

Director Hamos commented that for this waiver, a network of services will be provided for these clients and Cook County will pay their bills. If providers come to HFS to pay the bills, there will be an edit in the department's system to forward the bill over to CCHHS.

VII. Follow-up Discussion on Committee Priorities for 2012

Chairperson Gordon stated there was discussion at the last MAC meeting on a number of ideas including Dr. King's tabled motion. She wanted to start today's discussion by reframing where we were and where we wanted to go. HFS' priorities are set by the Governor, Medicaid law and the Illinois General Assembly. The MAC can advise HFS on priorities, but must recognize that these are set in the broader arena of Washington and Springfield. Chairperson Gordon suggested that the MAC talk about the big priorities or topics and then send to appropriate subcommittees to work on.

At the last meeting, Ms. Eagleson shared that HFS' priorities are coordinated care, innovations, rate reform and the looming program budget cuts that it will have to implement. Chairperson Gordon stated that we are here to talk about the things that people relying on Medicaid really need to have. The broad topics are: mental health, health care disparities, adolescent health care, lack of specialty care for children and specialty care in general.

Chairperson Gordon asked if there were any additions to the list and opened the floor for comment. A thoughtful and lively discussion on priorities followed, as summarized below.

- There is a need to address how the community gets to weigh in on the programs and services that HFS is providing and how that input takes place.
- The specialty care topic is more about finding specialists for adults. There was a plan put in place to facilitate access in Cook County. The focus needs to be on reporting back to know that the plan is working. The emphasis is in knowing that over the years there are so many plans and we still see these disparities. Are people getting their appointments at Cook County now?
- Part of the conflict is separating policy from execution. When we put them together in a single discussion and when there is lack of execution, we go back to what is wrong with the policy. There may be nothing wrong with the actual policy, but rather how it was implemented. It would be beneficial to take the operational pieces and establish work groups to analyze those elements to determine where the gaps and breakdowns are occurring.
- Historically, the MAC has had a lot of data reporting, but very little programmatic review. We don't get to determine if we are getting value for the dollar. As an advisory committee, the intent was to provide input to HFS in saying we want to advise you on gaps, services that are missing in the total system, as well as those areas you are serving already and how can we improve that to make it better. We are trying to figure out how to effectively use the dollars available at a time when fewer dollars are there.
- There is a data component for coordinated care. The director of research has attended coordinated care meetings and is charged with helping get data out to the various groups trying to participate in Innovations.
- As these priority recommendations move forward through the various subcommittees assigned, HFS would also ask for a recommendation on how that subcommittee feels it is appropriate for HFS to track what they are asking us to do. This is requested so HFS has a way to measure it on an ongoing basis and so the MAC may see the progress against that goal.
- The Care Coordination Subcommittee provided input to HFS as it moved forward with the innovations solicitations. The subcommittee is now looking at how to measure and improve quality.

- HFS is moving toward looking at performance and outcomes in terms of quality and not just quantity. It is more the charge of the Care Coordination Subcommittee to look at outcomes as the department is measuring this in many of the reports it is doing. Quality has to be linked to a program and linked to say how many clients are getting timely access to specialized care.
- In terms of adolescent health, it should tie into HFS' perinatal plan, as Medicaid pays for about 93 percent of teen births. In the CHIPRA report there are over 20 measures and the state reported on only seven. Some of those measures are adolescent measures. Adolescent health is listed as a priority, because the MAC hasn't heard much about it.
- Ms. Shapiro stated the topic areas are more evaluation parameters for understanding Medicaid program effectiveness. There are so many programs coming out of HFS right now with many changes. Maybe this is the time to say let's follow the "storyboard". If we have an innovation, then follow the storyboard and see if the innovation is effective.
- It goes to the issue of how you structure work. The move toward adopting organized systems of care is exactly the strategy the department has adopted to do a number of things such as addressing quality, access and financing. Care coordination affects all those things and is integral. This is clearly something HFS has adopted, with statue behind it, and with initiatives on the street. Populations have been prioritized to start with so it is not across the board yet, but it's moving in that direction. It would be helpful to know whether MAC members recognize that as the framework, as it is clearly all there.
- The department thinks about financing in Innovations as having our payment systems aligned with provider care and behavior. It is not a question of can we afford it, but how can we do it better or more effectively. The Innovations Project is about how we can redo and rethink our payment methodology.

  Director Hamos indicated that she took the issue of children's mental health to the Human Services Commission. As part of their mission, they are creating a workgroup to look at this as more of a systems issue asking how it impacts the various systems and what do we really need to do to fill in the gaps. The process is just now starting as it requires multiple agencies sitting around the table. If adolescent health care is a priority for the MAC, then we should create a substantive committee around that and try to bring in all the players, such as school based clinics, to talk it through and figure it out on a system wide basis.

  Kathy Chan stated that the IMCHC runs the Illinois School Based Clinic Coalition and would welcome conversations about these issues. There are a lot of groups that are present in the room and also may not have the opportunity to come to these meetings that are working on these issues. She suggested it would be great to come up with some concrete "asks" to bring back to the MAC or to a subcommittee. Ms. Chan noted that there is effective advocacy work, as well as substantive program work, going on outside the MAC and bringing it back to this venue would be helpful in moving forward.

  Dr. King stated that her concern is looking at whether or not Illinois Medical Assistance program beneficiaries or potential beneficiaries are able to access and receive the care that they should receive. If there are barriers to adolescents getting that care, it is an issue for Medicaid. The insurer needs to be responsible for having those conversations and making sure programs are in place and working. She said a piece of this should be reporting.

  Diane Montañez stated that she doesn't think the state is in the position right now to really explain follow up and quality. As the state moves into coordinated care and managed care, a lot more detail can be provided because the level of reporting and the level of accountability under these new systems is much higher than we have ever had. The state is not in a place right now to measure some of these service outcomes.

  Mr. Pick summarized that Chairperson Gordon is trying to solicit a motion to establish some structure where subcommittees are given charges. He suggested that as a priority for the MAC our charge is to assure that populations that are being covered by Medicaid are receiving access to quality care in a timely manner that meets their needs. From there we can look to whether the area of focus is programmatic or by population or condition. The areas of focus begin to identify whether we are meeting that policy statement. For example, we

have a committee like "Long Term Care" or "Public Education" and their charge has been in place to evaluate the programs. What we are saying is that we want to modify that charge to use this overarching policy to see whether from a programmatic standpoint the policy initiative is being met.

Director Hamos suggested that maybe we look to create a subcommittee on access. One could look at specialty care under that and could take it by population or by provider or service and do some very interesting thinking. We need to focus and find a place where we can really hone in on some of the priorities.

Ms. Fager suggested creating a "School Based Health" subcommittee, stating that there is much activity in CPS right now on this subject. It is a national phenomenon in many ways as schools are standing up to the plate for public health. We now have a new health officer at CPS, who will be reporting to the Chicago Dept. of Public Health and the head of CPS. There is a huge number of wellness initiatives being funded and implemented. CPS has a huge optical care program for children who failed their vision screening and somehow their HMO didn't pick up the cost.

Ms. Chan noted that there is a school health task force and that the IMCHC School Health Center director is on that task force. She could get more information and share it.

VIII. Discussion of Subcommittees

Chairperson Gordon identified the current subcommittees as Care Coordination, Long Term Care, Pharmacy, Public Education and Dental. It was suggested that the MAC to add two new subcommittees: Access and School Based Health. She suggested that school based health could be part of the Access Subcommittee. She asked how members would feel about creating a new Access Subcommittee and retiring the Pharmacy Subcommittee.

Mr. Pick offered a motion to sunset the Pharmacy Subcommittee. The motion was seconded by Ms. Driscoll.

There was discussion on HFS public involvement in pharmacy as a lot of people have concerns about accessing medication. Ms. Eagleson stated that the department has a Drug and Therapeutics Committee that has two parts, clinical and public. Director Hamos noted that this is part of HFS' public involvement and that MAC members could be invited to that committee.

- The seven MAC members present voted (six in favor with one abstention) to sunset the Pharmacy Subcommittee.

Mr. Pick made a motion to establish a new Access Subcommittee. The motion was seconded by Dr. King. Mr. Pick then suggested that the MAC chairperson and HFS consider who it would like for the new subcommittee chair and discussion with that individual include formulating a subcommittee charge that could be adopted by the MAC at the next meeting.

MAC members were polled to see if they would be willing to participate on the new subcommittee by attending and reporting the work of the committee to the MAC. Ms. Shapiro, Ms. Driscoll, Ms. Chan, Mr. Pick and Chairperson Gordon indicated a willingness to participate.

- The seven MAC members present voted all in favor of establishing a new Access Subcommittee.

Dr. King stated that her motion from the last meeting that had been seconded and then tabled had not yet been resolved. She said that the actions taken today still do not address her motion, which is about asking HFS to prioritize those inequities in a more explicit manner than it does.

Chairperson Gordon asked Dr. King to restate her tabled motion. Dr. King presented the motion as follows: "The Medicaid Advisory Committee recommends 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, HFS should publicly report on its efforts to correct any identified inequities and disparities.

Director Hamos stated that she agrees with what she believes to be the intent of Dr. King's motion. However, big important ideas have to be packaged in a way that HFS can really do something. Taking on health disparities is so big that it is hard to imagine that we would do it well, unless someone could focus it. Director Hamos explained that what was interesting about Dr. King's point is that for all these years Medicaid has been a fee-for-service system and now we have a very different reorientation of our mission. HFS has basically been letting people go out and shop for services, asking our provider community to figure it out, and then, hopefully, step up to the plate, send us the bill and we will hopefully pay it. She stated that HFS' approach today is different. And, with all of the state and federal mandates HFS is currently working on, Dr. King's suggestion needs a focus and a strategy behind it.

Ms. Shapiro stated that there is already some evaluative material that is being done that would just be an agenda item for the MAC. What Dr. King brings to light is that there is intent, a program is created and some money is spent. Then we have a report to look at. What we can look at as a group is the intent and the plan to evaluate. It brings up the idea of delivery of care and using the expertise around the table to reform delivery of care in any way we can evaluate through a narrow lens that has specific focus.

- The seven MAC members present voted two in favor, four opposed and one abstention. The tabled motion was not passed.

Mr. Pick asked if the group could go back to the policy statement he had raised about the current MAC charge. He suggested that the statement could be used as a prism to evaluate how access to quality care in a timely manner based on client needs fits with the existing MAC charge.

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

Director Hamos noted that the statement is under Article 1 – Name and Mandate. She suggested that we could add another section that is the MAC vision statement.

Ms. Ellinger added that making this change includes a notice requirement and should be published in advance of the MAC meeting to allow action to amend the by-laws. Ann Lattig could help with publishing. Also someone will need to help write the amendment.

Chairperson Gordon hoped that a motion to amend the bylaws could be brought up at the next MAC meeting. She summarized that today the MAC has made the access issue the new priority for 2012 and within that all the other issues fall. She stated that we looked at the subcommittees and created the new Access Subcommittee; and asked for a motion regarding the committee's intent to both amend the MAC bylaws with a vision statement and include it as part of the charge statement for the new Access Subcommittee with the following language: "To assure that populations that are being covered by Medicaid are receiving access to quality care in a timely manner that meets their need regardless of race/ethnicity, primary language, geography and age." Mr. Pick made the motion and Ms. Driscoll seconded.

- The seven MAC members present voted unanimously to accept the motion of its intent to amend the MAC bylaws with a vision statement and include the language as part of the charge statement for the new Access Subcommittee.

IX. Subcommittee Reports

Public Education Subcommittee Report

Ms. Chan provided the report. MAC members were provided a copy of the subcommittee charge that showed recommended revisions as track changes (Attachment 2). She advised that these changes were presented at the last subcommittee meeting. Input was solicited from committee members, as well as everyone who has been participating. Ms. Chan moved that the MAC adopt the revised charge. The motion was seconded.

- The seven MAC members present voted unanimously to accept the revisions to the Public Education Subcommittee charge.

Long Term Care Subcommittee Report

The report was deferred to the next meeting.

X. Open to Committee

Due to time constraints, the floor was not opened for discussion of new topics.

XI. Adjournment

The meeting was adjourned at 12:05 p.m. The next meeting is scheduled for May 18, 2012.

1115 Waiver Concept Paper

Cook County Health & Hospitals System

The Cook County Board of Commissioners and the Cook County Health and Hospitals System (CCHHS) are seeking an 1115 waiver from the Centers for Medicare and Medicaid Services (CMS), effective July of 2012, to cover the current uninsured population within Cook County that will become eligible for Medicaid in 2014 under the Affordable Care Act (ACA). The State of Illinois has submitted the waiver to CMS, with a statement that it is contingent on legislative authorization to create an exception in the 2-year moratorium on eligibility expansions pursuant to the state Medicaid Reform legislation of 2011. Key components of the proposed waiver include:

- **Population:** More than 100,000 patients currently in the CCHHS system could gain coverage.

- **Benefits:** Proposed coverage will be comprehensive but more limited than traditional Medicaid. Core benefits will include inpatient and outpatient hospital services, physician services, prescription drugs, mental health services, emergency services, and other benefits.

- **Network**: Primary intent for services under the waiver would have a major focus on the CCHHS system initially with a regionally-developed network.

- **Care Coordination Model**: A customized patient centered medical home model will be used.

- **Payments**: Payments will continue to be structured as are current CCHHS payments in the short term – funded by county (local share) and federal (matching) funds. Payments will likely move to bundled or per member per month over time to comport with HFS statutory care coordination goals.

- **Enrollment**: CCHHS and current eligibility vendor to find patients currently receiving medical services from CCHHS. Eligibility process will incorporate strong fraud and abuse protections. CCHHS has agreed to fund any increased administrative costs related to eligibility determinations and, further, will assume responsibility for costs arising from the administration of the waiver application or its implementation.

- **Medicaid Provisions:** While the Affordable Care Act (ACA) allows states to expand Medicaid before 2014 in this manner, this plan would require a waiver of the Medicaid "freedom of choice" and "statewideness" requirements and perhaps "comparability of services" provisions. While the waiver is written with an emphasis on CCHHS, the waiver could be adapted for other Illinois counties with an interest and health care system with similar ingredients – as long as those counties are willing to pay the local share (50%) as does CCHHS.

- **Cost:** Legislative language will be crafted to make the proper assurances that no state moneys will be expended including the assurance that if ACA provisions that enable the state and county to **both** financially benefit from the 1115 waiver are struck down by the courts, the state and county will abandon the pursuit of the waiver.

Public Education Subcommittee

The Public Education Subcommittee is established to advise the Medicaid Advisory Committee concerning materials and methods for informing individuals about health benefits available under the Department of Healthcare and Family Service's medical programs including, but not limited to, All Kids, FamilyCare, Aid to the Aged, Blind, or Disabled (AABD) medical, Illinois Cares Rx and Illinois Healthy Women.

The subcommittee, comprised of a diverse group of stakeholders, will:

1. review and provide advice on brochures, pamphlets and other written materials prepared by the department;
2. review ~~informational~~ projects designed to inform the general public about medical programs;
3. serve as a conduit for informing the Medicaid Advisory Committee and the Department concerning ~~education needed or~~ gaps in public understanding of the medical programs~~, and~~;
4. propose additional means of communicating information about medical programs, and:~~.~~
~~4.~~5. review and provide advice on program eligibility changes, customer service delivery, and eligibility processing systems.