Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee - May 10, 2013

Members Present
Susan Hayes Gordon, Chairperson
Kathy Chan, IMCHC
Mary Driscoll, DPH
Jan Grimes, IHHC
Judy King
Andrea Kovach, Shriver Center
Karen Moredock, DCFS
Edward Pont, ICAAP
Linda Shapiro, ACHN
John Shlofrock, Barton Mgt.

HFS Staff
Julie Hamos
Theresa Eagleson
Arvind Goyal
Michelle Maher
Molly Siegel
Mike Jones
Sally Becherer
Jennifer Partlow
Jamie Tripp
James Monk

Interested Parties
Frank Anselmo, CBHA
Lindsey Artola, Presence Health
Victoria Bigelow, Access to Care
Karen Brach, BCBSIL
Libby Brunsvold, MedImmune
John Bullard, Amgen
Kelly Carter, IPHCA
Carrie Chapman, LAF
Joe Cini, AHS
Gerri Clark, DSCC
Julie Curry, Curry and Associates
Deila Davis, Access
Mark Davis, Vertex Pharmaceuticals
Ellen Dooley, Community Care Alliance of IL
Thomas Erickson, BMS
Paul Frank, Harmony/Wellcare
Pat Gallagher, IHA
Jan Gambach, MHCCI
Jill Hayden, HealthSpring
Marvin Hazelwood, Consultant
Laura Jaskierski, IL Health Insurance Marketplace
Margaret Kirkegaard, HMA

Members Absent
Eli Pick, Post Acute Innovations
Renee Poole, IAFP
Glendean Sisk, DHS
Sue Vega, Alivio Medical Center

Interested Parties continued
Phillipe Largent, LGS
Theresa Larsen, Meridian Health Plan
Dawn Lease, Johnson & Johnson
Puneet Leekha, Popovits and Robinson
Hong Liu, Midwest Asian Health Association
Marilyn Martin, Access Living
Mona Martin, PHRMA
Grace Martos, Molina Healthcare
JoAnn Mason, Meijer
Marty Matthews, Merck and Co, Inc.
Susan Melczer, MCHC
Emily Miller, IARF
Diane Montanez, Alivio
Phil Mortis, Gilead
Jonathan Mthombeni, Byram Health
Mike Murphy, Meridian
Sanjoy Musunuri, Aetna
Dennis Myleskie, Johnson & Johnson
Jewell Oates, CBHA
Heather O'Donnell, Thresholds
Dana Popish, BCBSIL
Emily Rakoski, Abbott
Sam Robinson, Canary Telehealth
Joel Roth, U of C Medicine
Phyllis Russell, ACMHAI
Ken Ryan, ISMS
Amy Sagen, UI Hospital & HS system
Heather Scalia, Humana
Bridget Bonne-Smith
Margaret Stapleton, Shriver Center
Bernadine Stetz, Molina Healthcare
Chet Stroyny, APS Healthcare
Bob White, Foucst
Ericka Wicks, Health Management Associates
Lisa Willshaw, MedImmune
Joy Wykowski, CCHHS

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

I. Call to Order

MAC Chairman, Susan Hayes Gordon called the meeting to order at 10:05 a.m.

II. Introductions

Participants in Springfield and Chicago introduced themselves.

III. Approval of March 8, 2013 Meeting Minutes

Some revisions were requested. The March minutes were approved with these requested changes:

- On page 3, regarding the large enrollment into coordinated care, Dr. Edward Pont had asked if HFS would break the numbers down to show how many established recipients will move to care coordination. He asked that the minutes reflect the Director's answer that the Department would prepare such a list and share it with various interested parties. Chairman Gordon suggested that the statement be changed to the Department would present such a list. Dr. Pont agreed with this change.
- On page 4, Dr. Judy King asked that her statement, "there was in her view, some inconsistent or confusing information from DHS and HFS about what happens to clients that don't respond within 10 days" be added to her question regarding clients that do not respond to a redetermination letter.
- On page 6, Dr. King asked that the statement regarding her support for the Department's drug prior approval review would be changed to read that she supports the Department's drug use review.

IV. Director's Report

Budget: Director Hamos reported that as the legislature enters the last few weeks of this session there were two things important of note; 1) The state got a $1.3 billion windfall in tax revenue that allowed the Department to pay off most of its back log of bills. 2) The bad news is that there is still a budget shortfall.

She said that every agency is being brought in to look for possible cuts and that last week HFS went through an exercise about how it might cut 15% of its operations budget -- not the medical side but the operations supporting the medical work, including things like claiming; new initiatives in third party liability; audit recovery; setting up appeals and grievance processes through the Department's general counsel's office; and setting up the program integrity unit. These are changes HFS is making to improve its overall program functioning. HFS doesn't know if any of these cuts will actually happen but if they do it would be painful.

Expansion of Medicaid: Senate Bill 26 (still pending) would allow the expansion of Medicaid as part of implementing the Affordable Care Act is still sitting in the house. The bill has become a vehicle for lots of stuff and could be a very big bill before this is all over. There seems to be different categories of requests. One of those is a group of advocates requesting various restorations under the SMART Act. Legislative leaders will need to look at what is being asked for and what the state may be able to afford.

Care Coordination roll-out strategy: The hospitals have brought an agenda forward that has made the Department think about its care coordination roll-out strategy. The conversation has been preliminary but HFS is thinking about doing a solicitation this summer for a pretty large expansion of care coordination for the children/family population through provider networks to see who might be interested in doing that hard work.

Reimbursement reform: For 2 years, HFS has been actively engaged with both the hospital and nursing home communities in looking at reimbursement reform initiatives. They are both using outdated methodologies. The Department is finalizing the plans for both hospitals and nursing homes. An implementation plan is posted on the website showing the hospital methodology including the timetable. On the nursing home side, it is a little less clear how it will play out. The Department is not sure if we will need legislation for that.

Q1: (Dr. Pont) **Can HFS implement the expansion of care coordination for the child/family population in 2014 if a solicitation goes out this summer?**
A1: Director Hamos stated that she really didn't know but HFS still has the mandate to put 50% of the Medicaid population into coordinated care by 2015.
Q2: Does this make the Department rethink its timeline for transferring 1.4 million patients including children into coordinated care over 2014?
A2: The Department thinks that the legislature should rethink the timeline to make sure it is realistic.

Q1: Is the SMART Act currently meeting its financial goals? Q2: Is there a way we can follow that?
A1: Last fall, the Department made the projections for savings using available methodology but with changes in enrollment and medical need it is hard to estimate that. In April, the Department reanalyzed its overall medical liability and found it within .7% of where we thought it would be. This is on a budget of almost $18 billion. HFS is currently meeting its financial goals, if they hold. There is a lag time with bills getting to us six month later.
A2: HFS did have a handout given to legislators and believes this is on the website.

Q: (Dr. King) **How did HFS decide which contraceptive medicines should be incented?** Last month there was an information notice regarding increasing payment for entities for certain contraceptives. It lists the diaphragm as highly effective but she didn't believe that this is technically correct.
A: After some discussion about 340B billing incentives and contraceptives, Theresa Eagleson Administrator, Division of Medical Programs, asked Dr. King to send HFS the inquiry to allow further review by program staff.

V. Update on Care Coordination Initiatives

Michelle Maher, Chief, Bureau of Managed Care provided the report.

Innovations Project: On the CCE side, project manager, Molly Siegel is working diligently with the five CCEs that were initially awarded through our solicitation. HFS is working with CCAI, the one MCCN that was awarded. They are in the contract development process. The Department also has help from Health Management Associates (HMA) with the implementation in providing support to the CCEs.

Dual Medicare/Medicaid Care Integration Financial Model Project: HFS has been working with the federal CMS on the three-way contract to be offered to all of the health plans. On the rate development, state actuaries and the federal CMS actuaries are meeting regularly to hone through all the detailed data to determine what the rates will be on both the Medicare and Medicaid sides. HFS hopes to have progress on that in early June.

The Department is still on track for voluntary enrollment beginning in October. HFS had a webinar on April 18 with participation by over 900 stakeholders. The questions and answers from that should be posted next week.

The Department received seven CCE proposals to provide care coordination for children with complex needs. HFS has set up the evaluation teams for those proposals and they are under evaluation now.

The Department is also working with some of the CCE applicants who did not get awards in the first round to talk through and strengthen their applications. HFS continues to have robust activity on CCE development.

VI. Alliance / SIM Project

Dr. Margaret Kirkegaard reported that HMA has been retained by the state to assist on this grant process. The Alliance for Health is the name applied to the grant in Illinois. The Center for Medicare & Medicaid Innovations (CMMI) through their states innovations model program has structured this program to provide grant funding to states in one of two categories, model design and grant testing. Illinois received about $2 million for a Model Design grant. This is anticipated to be a 6 month process bringing together innovations across Illinois to create a

cohesive, integrated, healthcare delivery plan. Once the plan is written, the state intends to apply for the model test funding. It would a three-year period to look at the outcomes of this model design and innovations.

For the model design grant, Illinois chose to look at 3 models of healthcare delivery that are currently going on in Illinois. These are: 1) The CCE model which is a provider driven model for innovations and improvement in the quality of care; 2) The traditional model of managed care health plans working together with providers to deliver care for patients, and; 3) The County Care model which is a unique model for expanding care to uninsured individuals and creating a managed care plan through an academic health center. We are working to develop this plan over the six month period from April through September 2013.

There is a steering committee composed of 70 to 80 people. They have met together once. Many of the people here today or their organizations are represented on that committee. Some organizations represented are ICAAP, ISMS and IHA as well as state agencies like IDPH, DOA and DOI. There is a broad range of stakeholders brought together to provide input into this process.

In addition to the steering committee, there are workgroups for data, delivery system and payment reform, and policy. The idea is that if the delivery and payment reform work groups recommend a particular innovation, then the policy workgroup can take that and determine if there are any particular policies that may be a barrier. She said that with all these groups working together, we can produce a coordinated, innovative plan at the end of 6 months.

There is additional information about what is happening nationally and in other states on the CMMI web page at: http://innovation.cms.gov/initiatives/State-Innovations-Model-Design/ Illinois has dedicated a webpage on the health reform implementation council at: http://www2.illinois.gov/gov/healthcarereform/Pages/Alliance.aspx The page includes information on the first steering committee meeting and other related documents. It is the intent of the steering committee to keep that page up to date. There is also an opportunity on this web page to make comments and suggests. She stated that one of the processes that CMS is looking at is stakeholder engagement and coordination with consumers. Dr. Kirkegaard encouraged people to use this website.

Q: What are the deliverables?
A: The plan is to build on the 3 existing models with innovations and integrate across them. There is a fairly sophisticated financial analysis that accompanies those models. There is a baseline financial analysis based on paid claims, insurance claims and Medicare claims that has to be integrated together. That is a large function of the data committee. UIC with their data workshop is helping us. At the end of the model testing and if Illinois is successful in getting the 3 year grant, the same financial analysis would be applied to look for savings.

Q: Are there other opportunities for public involvement besides submitting questions thru the website?
A: Yes. The steering committee is planning to have a town hall meeting in conjunction with the next Health Reform Implementation council meeting scheduled for June 6. There will be some dedicated time to describe the Alliance process and solicit feedback from anyone with a question, concern or suggestion for an innovation.

Q: Is Medical Home Network (MHN) a part of this?
A: MHN is involved in the project but as a specific model. It is part of the CCE model.

Q: Will you be looking at customer satisfaction as an evaluation outcome across the three models?
A: The goal of this project is not to compare the three models but to integrate them. The Alliance process can set its own metrics that would be measured at the end. As part of the state healthcare innovation plan, client satisfaction could be one of those metrics.

Q: Where would place an Accountable Care Organization (ACO) model?

A: While some of the health plans and providers are looking at accountable care, we haven't looked at that as an individual model. The CCEs have some elements of accountable care with some of the things going on with them. Accountable care is more of a philosophy rather than a component of this.

Q: How much money is available that you are pursuing at the federal level?
A: For the model design phase, about $2 million and up to $60 million in the 3 year model testing phase.

VIII. Market Place

Laura Jaskierski representing the Illinois Health Insurance Marketplace reported that on October 1, 2013, open enrollment will begin on the Marketplace. Uninsured and underinsured low and middle-income consumers will gain access to quality, affordable health coverage, with the ability to compare plans online and choose the one best for them with financial help and in-person assistance. The Marketplace will run as a federal/state partnership. The federal government will control the website and take applications over the phone. Illinois will have regulators review qualified health plan applications; oversee in-person assisters; and run a paid and earned media campaign. Illinois has been preparing for its partnership responsibilities.

In April, Illinois was awarded a $115 million grant for implementation of the Marketplace, including funding for in-person counselor grants, procurement of a private marketing firm, and dollars to build an IT infrastructure pending legislation. At the end of April, qualified health plan applications for major medical coverage on the Marketplace were due to the Illinois Department of Insurance (DOI). DOI received applications from 6 health insurance carriers seeking to provide 165 qualified health plans. Also, the stand-alone dental plan application is expected to become available at the end of May. All applications will be reviewed by DOI to determine if they provide the required Essential Health Benefits, meet required actuarial standards, meet network adequacy standards and do not discriminate by discouraging purchase by people with health issues. DOI will recommend to HHS which applicants should be certified as qualified health plans by the end of July. HHS will make their final determinations by the end of August.

Additionally, as specified in the Illinois Outreach and Education plan that the Marketplace team submitted to HHS in March, Illinois is committed to promoting a culture of coverage. Preparing Illinois consumers for this new coverage opportunity is an important role to fill. National research found that 78% of uninsured adults lack awareness of new insurance options under the Affordable Care Act (ACA). The Marketplace's outreach effort will be run like a campaign, with paid media and on-the-ground components.

A private marketing firm will help educate consumers, motivate them to enroll, and transform the public's perception of the importance of having coverage regardless of the source. Illinois issued a request for proposal for a marketing firm to implement market research; branding efforts; a public relations campaign; including the development of ads; an online landing page; and a data analytics tool to track marketing and outreach efforts. This week, 13 marketing firms submitted proposals.

For the on-the-ground campaign, HHS and Illinois will give grants to "Assisters" across the state to provide in-person assistance, help the uninsured complete the Marketplace's online application and choose the private health plan that is best for them. These Assisters will follow a "no wrong door" policy and, therefore, also help Medicaid- and AllKids-eligible consumers apply through the Application for Benefits Eligibility (ABE). These Assisters will receive federal and state training and be certified by the DOI. Organizations participating in the Illinois Assister Program will fall into one of three categories: Navigators, In-Person Counselors, and Certified Application Counselors. The difference between the categories is funding. Navigators will receive funding through a federal grant, In-Person Counselors will receive funding through a state grant, and Certified Application Counselors will not receive federal or state funding for their enrollment activities.

The Illinois Department of Public Health, in coordination with the Marketplace, has issued a $28 million In-Person Counselor grant opportunity and will be accepting applications through May 30. The federal government

also made available $2.3 million in Navigator grants, with applications due on June 7. All entities within the Illinois Assister Program, regardless of category, will perform the exact same enrollment assistance functions for different demographic and geographic audiences, receive nearly identical training, and be subject to the certification standards and oversight procedures of the Illinois Health Insurance Marketplace. Assisters will work together through Community Coverage Networks reporting up through eight regional outreach directors.

Illinois expects both state training for Assisters and the media campaign to begin at the end of July. There is a lot of work to do before open enrollment begins October 1, 2013 and coverage begins January 1, 2014. The Marketplace is diligently preparing to help consumers gain access to the new coverage opportunities made available by the ACA and committed to meeting the goal of enrolling 486,000 consumers in 2014.

Q: Can you tell us a little more about the regional outreach directors?
A: These will be Marketplace employees that are distributed throughout the state based on where the grantees and uninsured are located. They will report to our director of outreach and consumer education, Brian Gorman.

Q: When DOI evaluates the health plans, will there be some criteria regarding continuity of care for persons moving back or forth between the Medicaid and the commercial health plans?
A: Some states may have a bridge plan that is an insurance plan that is in both Medicaid and commercial insurance offered on the marketplace. It is specifically targeted to persons near the eligibility thresholds that would potentially churn back and forth. The bridge plan is only allowed for states that run their own marketplace. Since Illinois' marketplace is a federal/state partnership, DOI is not contemplating using such criteria in the first year of operation but would like to do so in the future. Ensuring continuity of care is something that we will monitor and that Assisters will work with clients to achieve.

Q1: Is DOI setting standards for network adequacy? Q2: If yes, where are these standards found?
A1: Yes. That is one area where Illinois is slightly above the federal standard. HMOs in the marketplace in Illinois have a specific standard laid out in the Managed Care Act. To level the playing field, DOI is requiring non-HMOs to meet the same network adequacy standards.
A2: Information on network adequacy can be found online at:

- DOI Guidance to Issuers: http://insurance.illinois.gov/cb/2013/CB2013-06.pdf
- Blueprint Application: http://www2.illinois.gov/gov/healthcarereform/Documents/Health%20Benefits%20Exchange/11%2016%2012%20Blueprint%20Application%20-%20final%20draft.pdf

Q: When will the rates be posted for the different plans that will be available on the Marketplace?
A: Part of that will be dependent on when the federal government is ready to post them. They have committed to certifying which plans will be listed by the end of August. When this is done, they will upload the data to their website. There will be a brief period to check that information was uploaded correctly. Initially the idea was that carriers would have a longer period of time and consumers could browse the website about a month in advance. As the deadline is coming closer there will be much shorter time for carriers to check that the information is correct and consumers may or may not be able to browse in advance.

Q: What kind of outreach was done to let people know about the grant opportunity to become Assisters?
Dr. King advised that she had heard in some circles an unawareness of these opportunities.
A: Director Hamos advised that the Governor's press release on this grant opportunity just went out four days ago. On the same day, HFS sent out the information to its public newsletter list of 33,000. There are always people missing from our list so it is important to share the information. Ms. Jaskierski noted that the news was shared via the Health Reform Implementation Council, a list of DOI stakeholders and was posted online by IDPH. She would appreciate participants spreading the word and also sharing suggestions for outreach.

Director Hamos suggested that the information also be sent to all the DHS grantees and the Department on Aging to reach a broader level of community folks.

Dr. King stated that she appreciated all of the lists and the recognition of persons not on the list. The point is in the beginning to think about people who are not engaged. That should be part of the objective.

IX. Prior Approval Policy

Lisa Arndt reviewed that the MAC had previously shared a concern about the timeliness of the Department in responding to requests by providers and pharmacists in making a decision on medications that required prior approval. She stated that the MAC had requested a random sample of 20 prior approval drug requests to show the processing time frames. She referred to a handout provided at the meeting that showed prior approval drug requests under the following field headings: Submission Date and Time, Adjudication Date and Time, Medication, Outcome and Reason, if denied. She shared that HFS has consistently responded to most of these requests within a few hours. Once requests are received, it takes up to a couple of hours to get them data entered and usually a determination is made within the next hour. There are some exceptions. For example if the Department needs to request additional information. HFS has moved a lot of the requests to the MEDI system. This means the providers are entering the requests into the Department's prior approval database and can get a response without calling or faxing requests. The Department's experience is that once providers use the system, they like working with it. She asked if there were any questions.

Dr. Pont commented on the folic acid request on October 3. He stated that folic acid is low cost, relatively benign and the fact that it gets denied, may give the inaccurate impression of the Department as a faceless government bureaucracy and some may ask why are they bothering the prescriber about folic acid.

Ms. Arndt stated the policy has been that the prescriber has to make the request under the 4-script override. HFS is working out a system to allow the pharmacist to make the request and help expedite the process.

Mary Driscoll added that it is always important to fill the folic acid prescription for women who are pregnant if a provider requests it. It has very beneficial effects.

Q: Could you explain more about letting the pharmacies override the prior approval process?
A: The Department has met with some of the pharmacies. HFS has decided to allow them, if they review the entire medication protocol, to make a 4-script override request. They will have to make the request for the whole patient profile in the same way as the other providers and be required to use the MEDI system. The Department is currently drafting a provider notice about this process and it should take about a month to get done.

Chairman Gordon asked if the pharmacist would be paid if the request were not authorized in advance. She wondered how many pharmacists would want to make the override request if they were not going to be paid.

Ms. Arndt responded that the pharmacist would need an approval in advance in order to bill the Department. She noted that pharmacists very much want to do this override process because ultimately it expedites them being reimbursed for the service. If the physician has to make the request, it could delay the approval.

Director Hamos asked if this is what the pharmacies call medication management? She noted that the pharmacists came to the Department last year during the SMART Act considerations to talk to about their future business model. They wanted to be much bigger players in working with the person presenting the script, looking at their whole regimen of care and being more involved in patient care. This is an example of a new kind of professional at the table with a new role to play.

Q1: (Carrie Chapman). **What is the final approval date for drugs that are approved but denied initially?** LAF clients are experiencing pretty substantial delays in that. On the handout, there is not a column for that.

A1: Ms. Arndt stated that the adjudication date is the date of the original denial. She advised that she could add a column for the final adjudication date for this situation.

Q2: (Carrie Chapman). **Can you tell us about the Department's long-term opiate use policy?** She had not seen a policy notice but there appears to be a policy being implemented.
A2: HFS is piloting a long-term opiate use policy. When we receive requests for patients who have been on opiates long term but don't see clinical justification that supports the use, we request more information from the prescriber and ask the prescriber and patient to sign a pain contract. HFS issues a one-month approval for the medication while the prescriber works with the patient to get the pain contract signed. Dr. Arvind Goyal, HFS Medical Director added that for Soboxone particularly, new criteria have been posted.

Q: (Dr King). **What are you allowing the pharmacist to do?** It sounds like you are allowing the pharmacist to decide when prior approval is needed and when a patient can continue medicines above the four-drug limit. Pharmacies always have the ability to review those medicines and contact the doctors if there is concern. Previously I heard that this was helping to have the prescriber do this process as often times they didn't know that the patients were taking these medicines. It seems like you're taking the physician out of the loop by putting it back at the pharmacy level.
A: HFS does expect the pharmacist to review the entire patient profile that they may not be doing when filling scripts. The Department would expect the pharmacist to communicate with the prescriber if there is a concern with duplication or a question about something in the medical profile and work with the prescriber to determine the appropriate medicine regimen.

Ms. Eagleson explained that the Department is allowing the pharmacist to play a facilitative role in the medication review and after reviewing the whole profile, submit it to HFS rather than having them go back to the doctor to submit the request.

Dr. Pont suggested that maybe the provider could receive a notice after that pharmacist approval just to be sure that they are aware of it.

X. Subcommittee Reports

Access Subcommittee Report: Chairman Gordon stated that the subcommittee chair, Eli Pick was not present but he had advised that there is not a report for this meeting.

Long Term Care (LTC) Subcommittee Report: Kelly Cunningham, Chief, Bureau of Long Term Care reported that the committee last met on March 22 and discussed the Department's compliance in meeting the goals of the SMART Act. HFS works to keep the website updated for legislative staff on our compliance with the 62 major policy changes ordered under the act. Some other major topics discussed are shown below.

Colbert vs. Quinn consent decree update Colbert vs. Quinn is one of the major class action lawsuits filed under the authority of the Supreme Court's decision in Olmsted and deals with the institutionalization of individual in nursing facilities. It is a Cook County based suit and covers 2000 class members with eligible individuals living in nursing facilities in Cook County. The implementation plan was a little slow in getting started and began in early November. At this point, HFS has entered into numerous contracts with community agencies managed care entities and some governmental agencies to help implement this consent decree. Much of the work centers on outreach to individuals in nursing homes and informing them of their rights to be transitioned to the community if interested. The Department has been getting some evaluations of those individuals done and determining who is appropriate for transition. We hope in our next major phase to get these moves accomplished. The court has given us some pretty specific time frames to meet later this year.

Balancing Incentive Program (BIP). This is a new grant opportunity offered under the ACA. Illinois applied in late March for BIP funding. The program is a government attempt to encourage states to rebalance their long

term care resources to create more home and community based options through the use of an enhanced Medicaid matching grant. The BIP requires the state to make some major systems reform in how it looks at assessment and evaluation and establishes some core domain to evaluate individual requests. It requires the state to provide a conflict free case management system and a "no wrong door" type of policy for entry into the long-term care system. The BIP will be in place for three years with the potential for the state to get as much as $90 million back to help support home and community based alternatives through this program.

Uniform Assessment Tool (UAT) – Request for Information (RFI) Mike Moss with the Governor's Office of Management and Budget made the presentation. One of the points of the BIP is to have an updated, modernized Uniform Assessment Tool or UAT. It takes the Determination of Need tool used now and updates it to bring more of the Long Term Supports and Services (LTSS) and community based direction into the process.

Through discussion with DHS, HFS and DOA that work with this now, HFS has issued a Request for Information (RFI) on the Illinois Procurement website at www.purchase.state.il.us and reference number 22030915. Hopefully it is possible to get the information out to the group after this meeting. The RFI is not just for vendors but also for stakeholders to respond. It is about screening and assessment tools. The state has been aware that there are many advances in this and many options available to states to acquire either an overall tool or several nesting tools that would do an initial screening of people, help to integrate all the different kinds of long term support services available, direct folks to proper services and also do more specialized determinations of need. The RFI includes a full background and questionnaire. There is a 30-day response period and the state encourages interested parties to respond. There is also an open option if somebody wants to demonstrate something with the current state of technology or ideas about this. As part of the response, you would tell us that and we would schedule something after the response period is closed.

Public Education Subcommittee Report: Ms. Chan reported that the committee last met in April. The primary agenda item was a review of notices from Maximus dealing with the Illinois Medicaid Redetermination Project (IMRP). The group spent some time going through them. HFS asked participants to submit comments after the meeting. At the next meeting, we expect to review the revised notices.

There was an update on the transition from the monthly to the annual issued medical card. Clients are now asked to retain their card. The card doesn't show a start or end date, so providers must verify eligibility. There was some discussion about providers denying services because there was not an eligibility date on the card and they were unfamiliar with the new format. If this is happening a report needs to go back to the Department. Robyn Nardone, who is no longer with HFS, was the point person. Perhaps HFS could identify a new contact person.

There was an update on the Application for Benefits Eligibility (ABE) that is expected to be operational in October. This is the portal by which individuals will be able to apply Medicaid as well as other public benefits including TANF and SNAP.

The next meeting is June 13 from 10:00 a.m. to noon in Chicago at Clinton Street and in Springfield at the Bloom Building.

Ms. Chan asked for a small change in the subcommittee's charge. She asked that reference to Illinois Cares Rx be deleted, as the program no longer exists. There was a motion made and seconded to approve this change. It was approved unanimously.

Care Coordination Subcommittee: Dr. Pont reported that the committee met on April 9. The meeting was interesting with a wide range of discussion. One minor issue is getting a quorum at the meetings with unapproved minutes now for the last four meetings. He stated that he would like to take it upon himself, if okay with the Director, to dismiss members who have not attended for three consecutive meetings. He also recognized Kelly Carter who has been at all of the meetings.

There were care coordination program updates from HFS staff on the RFP for children with complex needs, the dual-eligibles entities and the CCEs.

Dr. Pont had focused the meeting on continuity of care. He is concerned that as we move from one model to another it is important that to the extent possible those patients are able to stay with their primary provider.

At the meeting, Dr. Pont had put forth three ideas that he felt were met with relatively little resistance.

1) A website clearinghouse for people who have never had a choice in the healthcare plan but will be asked to make a choice will have access to information on the different health plans.
2) There should be increased visibility of care coordination. He has heard from some physicians that are in the ICP that did not see a significant change how the patients were being cared for and what supports they had coming from the various plans. Related to this, there is a need to improve reimbursement for specialists. This has been difficult to do after trying both legislatively and administratively. Perhaps with the MCOs who are able to provide more payment flexibility, we may get specialists the reimbursements they deserve.
3) There are patient populations that are generally low-risk, for whom the risk of disrupting continuity of care is outweighed by the advantages of care coordination. For those populations, a fee-for-service option should exist if the PCP is not in the plan to which the patient is assigned. This last suggestion was met with three arguments that he wished to address and are paraphrased below:

   Argument: The Department saves money with care coordination.
   Response: There is no real savings in care coordination for a low risk child.

   Argument: Providers would miss care coordination opportunities, as the child is not enrolled when in need.
   Response: Low risk patients generally will not need a lot of support.

   Argument: There is adverse risk selection meaning the MCOs will be overloaded with sick children.
   Response: A doctor choosing not to join a plan leaves many low risk kids to be assigned to a MCO.

Some common goals for the MCO plans were also discussed. Standardized billing information was one goal. Dr Jones made valuable contributions in discussing common goals. The next meeting is July 9.

Q: (Ms. Chan). **Is there any update on the Department looking at a global waiver?** At the Care Coordination meeting somebody from the Department brought up looking at a global waiver. It would be an 1115 waiver that would include all Medicaid programs and spending and that HFS would come up with a concept paper.
A: The Department doesn't have an update but may still pursue the idea.

Dr. King commented that the Illinois Medicaid Redetermination Project (IMRP) reports focus on the number of people screened and the consistency in the decision making between Maximus and DHS. She would like to see the reports enhanced to show more detail about the reasons cases are canceled; the number of persons re-enrolling after being canceled; and referrals to County Care when people lose eligibility when children age-out.

Director Hamos stated that the Department had to make a quarterly IMRP report to the legislature and listed the year to date activities. It also gave an explanation of the fact that DHS caseworkers were supposed to give a reason why they did or didn't agree with the Maximus decision but a very large percent of the workers forgot to do that. DHS caseworker staff will now have to enter the reason before they can finalize that case action. The Department should have that information in the future but probably not as a monthly report. Secondly, she noted that about a third of the cases that are canceled will re-enroll. That is the historical trend. HFS will not know if that trend continues until about four months into it and does plan to track that.

Dr. King also wanted HFS to make people aware that there is a Client Enrollment Broker website that is being updated but it doesn't include information on County Care. The website is http://www.enrollhfs.illinois.gov//

Joy Wykowski, Director of Intergovernmental Affairs with the Cook County Health and Hospital System stated that County Care has its own website at www.countycare.com. She was not aware of what links were available on HFS for County Care as an option but would be willing to work with HFS to have a link.

XI. Open to Committee

Dr. King would like a public discussion on network adequacy and what it means. It was an issue with the Integrated Care Plan. MAC should look at the Medicare Advantage standards and compare them to the network adequacy standards for Illinois Health Connect. She would like HFS to explain how it is measuring and monitoring network adequacy. She noted that she had asked how HFS would measure the bump in the primary care payment and the response was just a list of physicians showing if they were active or inactive with no information about specialty care.

Andrea Kovach added that regarding network adequacy, she would like to know if County Care was having any problem with finding primary medical homes for their enrollees and would also like updated enrollee numbers showing how many people have applied and how many have been enrolled for County Care.

Ms. Driscoll also wanted to find out the number of enrollees in County Care and where they're getting primary care, either at the county system or the FQHCs in the larger network. She asked about the system for the return to county for specialty referrals or hospitalization and how the system is working? She noted that a part of the waiver was the benefit of keeping the safety net system alive and if all the dollars go out the door to other places and don't come back to the safety net system that is really not the purpose.

Director Hamos asked what she meant by "dollars going out the door to other places".

Ms. Driscoll answered with the example of someone signing up for primary care at County and opting to go to Erie Family Health Center. Erie Family gets the Medicaid reimbursement rates for those folks and that is fine. If that person needs specialty care will that come back to County or will that go somewhere else in the network? How does that work and flow together?

Linda Shapiro stated that County did ask the FQHCs what their continuity of care preferences were and then reached out to those hospitals and diagnostic centers and offered them a contract. Some said yes and some said no. It is a network adequacy issue again. She added that maybe when we do the evaluation next time or get an update on County Care, we can also look at the whole network system and how it is being used.

Ms. Wykowski responded that the County Care website lists the FQHC providers with contracts to provide primary care services and then also the hospitals that those FQHCs are tied to and that provide those extended services. The point is to try and keep the patient's care close to their home. Those things are on that website but we can keep that as part of the report for the next meeting.

Ms. King asked Ms. Wykowski if she could also add information on the behavioral health providers as that is not on the website. She added that in reference to the waiver, it is her understanding that there is supposed to be a public forum at about six months to review County Care. She asked when that public forum would be.

Ms. Wykowski responded that County Care entered into a contract with PsycHealth for behavioral health services and all services go through that contractor. She could look for information on each individual provider that PsycHealth works with. She was not sure whether that is listed on the website or what that access is but she can address that. Regarding working with any kind of review process or public meeting, we could look at during the report at the next MAC meeting.

Ms. Hong Liu with the Midwest Asian Health Association asked that Ms. Wykowski to repeat the website for County Care. She advised www.countycare.com

XI. Adjournment

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