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Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee - September 21, 2012

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

Members Present
Susan Hayes Gordon, Chairperson
Mary Driscoll, DPH
Edward Pont, ICAAP
John Shlofrock, Barton Mgt.
Eli Pick, Post Acute Innovations
Judy King
Andrea Kovach, Shriver Center
Joe McLaurin for Linda Shapiro, ACHN
Jan Grimes, IHHC

Members Absent
Kathy Chan, IMCHC
Glendean Sisk, DHS
Sue Vega, Alivio Medical Center
Renee Poole, IAFP
Karen Moredock, DCFS

HFS Staff
Julie Hamos
Theresa Eagleson
James Parker
Jacqui Ellinger
Arvind Goyal
Robyn Nardone
Debra Clemons
Sally Becherer
Kim Wagenaar
Andrea Bennett
James Monk

Interested Parties
Craig Alexander, Community Care Alliance
Christopher Beal, OAP
Jane Bilger, CSH
Kathy Bovid, Bristol-Meyers Squibb
John Bullard, Amgen
Chris Burnett, IARF
Mary Capetillo, Lilly
Kelly Carter, IPHCA
Carrie Chapmen, LAF
Joe Cim, AHS
Viviane Clement, Shriver
Laurie Cohen, Civic Federation
Mathew Collins, Health Spring
Danielle D'Alessandro
Melissa Dannenberg, Molina Healthcare
Dru Duncan, Pfizer Inc
Chris Dunn, Conlon & Dunn Public Strategies
Andrew Fairgrieve, HMA
Gary Fitzgerald, Harmony-Wellcare
Ramon Gardinhire, Aids Foundation of Chicago
Donna Gerber, BCBSIL
Dean Groth, Pfizer

Interested Parties
Marvin Hazelwood, Consultant
Brian Hedinger, Jazz Pharma
Joe Holler, IHA
Nadeen Israel, Heartland Alliance
John Jansa, Molina Health
Glen Johnston, GSK
Andy Kane, Kane Consulting
Nicole Kazee, U of I Health Systems
Kristin Keim, Abbott
Mary Kennedy, ACAP
Keith Kudla, FHN
Phillipe Largent, Consultant
Dawn Lease, Johnson & Johnson
Helena Lefrow, MCHC
Shari Lewis, SCCP
Mona Martin, PHRMA
Deb Matthews, UIC-DSCC
Robert Medonsa, Aetna Better Health
Diane Montañez, Alivio Med Center
Heather O'Donnell, Thresholds
Ena Pierce, HealthSpring
Luis Quinones, ICIRR
Sam Robinson, Canary Telehealth
Tony Rossi, Med Immune
Joel Roth, University of Chicago
Phyllis Russell, ACMHAI
Ken Ryan, ISMS
Nancy Sacks, Community Care Alliance
Amy Sagen, UI Hospital & HS
Robert Spaulding, Healthcare Plus Senior Care
Michael Specht, Pfizer
Bernis Stetz, Molina Healthcare
Johnathan Thomberi, Byrain Healthcare
Cynthia Waldeck, Heartland Alliance
Matt Werner, Consultant
JulieYoungquist, Lawrence Hall Youth Services

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I. Call to Order

Chairperson Susan Gordon called the meeting to order at 10:04 a.m.

II. Introductions

Attendees in Springfield and Chicago introduced themselves.

III. Approval of July 20, 2012 Meeting Minutes

Dr. Judy King asked that the following sentence be added to the 3rd to last paragraph on page 4: HFS should assess the impact of this policy change on women's access to these contraceptive devices. With this change, minutes were approved.

IV. Director's Report

- HFS Director, Julie Hamos began by welcoming new HFS medical director, Dr. Arvind Goyal. He has sat with us at the table before but was not officially appointed. We are pleased to welcome him now.

- HFS was recently blasted in a press release for something the department supposedly "didn't do". One of the important initiatives in the SMART act is requiring that HFS and DHS contract with a private vendor to make sure that all of the annual redeterminations get done. That ultimately means touching 2.7 million case files or 1.45 million cases. It is a big job. Getting these done annually is one place the departments fell down. With increased enrollments and caseworker capacity to serve diminished, the DHS (FCRC) offices were overwhelmed by enrollment and caseload demands. Because of this, the annual redeterminations were not getting done.

  The Governor and the department embraced the concept that additional resources were needed to do this job well. Maintaining the integrity of the public assistance program is just as important as anything else the department is doing. Under the SMART act the department could look for a private vendor to provide back-up support to casework staff in completing redeterminations or canceling cases, which are actions set by federal law that only casework staff may complete.

  The vendor would provide two kinds of support. One is data matching that uses sophisticated national databases to determine things like income, assets and residency status. The second support is setting up an eligibility call-center that would be in touch with clients in case there is a question that is uncovered in the data match. The vendor plans to bring in nearly 500 people when fully staffed. Once the vendor has all the backup information in place it would be shipped to the caseworkers to make the final eligibility decision.

  HFS took this responsibility very seriously. On the date the Governor signed the bill, June 13th, HFS set out to create an RFP from scratch. An RFP was issued one month later. HFS held the mandatory bidders' conference giving potential bidders a chance to ask questions. HFS staff responded to 200 questions. The bids were evaluated. One month after the RFP was released. HFS issued a recommendation to award on August 13th.

  HFS had one month to negotiate the contract with the new vendor, Maximus. Their subcontractor for the data matching is HMS, a national database firm. This was completed on September 13th. It was important to build performance measures in the contract to ensure that cases were not simply being eliminated when clients actually remained eligible or inadequate planning created backlogs, or that clients had long wait times to contact the call center.

  Five days later there was a press release accusing the department of "dragging our feet". The person responsible for the press release filed a resolution stating that the contract work should begin on October 1, just 2 weeks after signing. This was problematic in that what HFS is trying to do is move things forward. The vendor, acting responsibly, had stated that it will take three months to get the contract started. Time is needed to sign a lease, set up furniture, phone lines and computers for 500 people, as well as hire and train people. The department and vendor must write protocols for cases with complicated factors, figure out a mechanism to transfer data back and forth, and determine what data is usable. The director stated that the department would not start the program until it is ready to roll out.

  Q: Dr. Judy King stated that she had heard concern that the contract is an attempt to eliminate people from access to care. She'd like to see what performance measures are being used. Her understanding is there will be projected savings of $350 million. She would like to know how the savings were determined. She referred to an All Kids map of procedures that she had sent to members this morning and would like to see a similar map to see how the changes would allow the savings.

A: Director Hamos stated the savings figure is not the department's number. As far as she knows there's no methodology behind it. The number got put into the budget but not by HFS. She advised that there are no incentives in the contract to cancel cases. There is a concept called "churning" that refers to a person being canceled because staff can't find them but they come back on the roles as eligible and needing service. HFS will be auditing the contractor to look at the churn rate. This will be one of the performance measures. HFS is not intending to knock people off but to restore program integrity. The performance measures are in the contract and the contract will be made available as we move through the process.

Q: Andrea Kovach asked if the departments have adequate staff to spend the time needed to make the final determinations.

A: Director Hamos replied that she believes staff understands that redeterminations are part of their responsibility. The law includes timelines for making those final decisions. The departments believe that some of the current casework responsibilities will be dealt with through the vendor's backup support. This will free up some time for caseworkers.

- Director Hamos reported on concerns regarding rollout of the Affordable Care Act (ACA) and what needs to be done in relationship to the state legislature. The department is estimating about 592,000 persons with income under 133% of poverty that are potentially eligible for medical benefits. The department believes that in the first year, there will be about a 50% take-up rate or about 296,000 persons will apply. Of those about 198,000 persons will be new enrollees and the others will be people that already qualify but have not yet enrolled. People that are qualified but not enrolled are referred to as "woodwork" as they come out of the woodwork to now apply. Over the next 3-4 years the numbers will ratchet up but there will still be some people potentially eligible that won't enroll.

  HFS and other state Medicaid departments have been debating what the Supreme Court has said about ACA. In Illinois, all of our eligibility policies and service packages are set out in law and administrative rules. Illinois has laws that are very detailed on every aspect of Medicaid. Therefore, HFS can't think about serving these new enrollees without getting legislative authorizations on serving them and what their benefit package will entail. HFS will need to get this done during the fall veto session that will go up to January 9th, before the new session begins. If we don't get authorization until the end of the next session, we will not be able to roll this out in January.

  One of the questions legislators will have is what benefits will the new enrollees be entitled to. This is a conversation that we still need to have. Director Hamos stated that she is still trying to figure out how to involve the MAC in this process. It is very difficult now to have this discussion right before the election as one day can decide which of two different directions we might be going. There is six weeks before the election. But if we wait this long before discussing there will not be much time for making the necessary decisions.

  Q: Chairperson Gordon asked if the benefits of the new clients would be different that those of current clients or is the plan to have benefits that are uniform with existing ones.

  A: Ms. Ellinger stated that under the ACA, Illinois can establish a separate benchmark benefit for new members. There are some essential medical benefits that are defined by the federal government. They have put out minimum guidance on what that includes. One concern in Illinois is that if a person is entering a nursing home, there is an asset test. This is of interest because we want people to use their own assets to pay for care before receiving taxpayer support. Most of middle class America may disagree, but it is our policy. For the newly eligible population, people who need long term care are likely to qualify as aged or having a disability and able to qualify under an old rule. It seems that loosening the rule and not having an asset test doesn't make sense for the state. HFS could make community based services available to the new enrollees or put limitations on pharmacy or other kinds of services that we don't have in long term care today. The long term care area is a place that there will be a lot of discussion.

  Q: Chairman Gordon asked if the comments that were due two days ago on essential benefits would be factored into the discussion about the legislation.

  A: Director Hamos responded that the comments influence discussions with the federal CMS. There are two things going on right now. HFS is planning for the expanded Medicaid group. At the same time, the state of Illinois through the Dept. of Insurance, as the lead agency and the Health Reform Implementation Council is also planning for the Health Benefits Exchange to determine what kind of plans will be offered and what the plans will have to offer to become qualified. That is the essential health benefit plan. There is a whole other effort going on to reach out to the public to get input on what should

be included in that. The federal government just gave some general guidelines. Now they will take those comments and try to give us some final rules.

Q: 1) Is any of this affected by the Cook County waiver meaning will one program override another? 2) For those "woodwork" enrollees, will the state be reimbursed by the feds for two years at 100%?

A: 1) Director Hamos answered the 1115 waiver has a narrower package of services and network. It is a managed care network of sorts. It is a 5 year waiver however HFS will have to agree with the feds on how we transition these waiver clients into whatever Medicaid expansion package is available. It may end up being only a 13 to 15 month waiver. **2)** The federal government will reimburse for only the new enrollees at 100%. For a person who'd have qualified under the old programs, meaning children, parents, and seniors and people with disabilities, the reimbursement rate would be 50%.

Q: Chairperson Gordon asked going back to engaging the MAC as we think about this legislation, what is the best way for us to be helpful? We would want a system that is seamless as people go back and forth from the health benefits exchange to Medicaid and back again. We don't want all these different benefit packages.

Eli Pick added that part of the difficulty is trying to follow several variables at once. We are talking about how the state is being reimbursed, what benefits are going to be available, and what providers are going to be responsible for them. It might be helpful if we try to separate the discussions. It is important for us to understand what the federal reimbursement level is to Illinois and what impact it will have on the funding available to pay for the benefits that will ultimately be in a package.

Historically under Medicaid, while different groups may have different benefit packages, groups within will always have the same type of benefit. In the private sector, within the same group there are different choices for an insurance plan. You could buy more insurance and have a higher benefit level. There may be some relevance to the discussion about different levels of benefits within the same group depending on the circumstances like old versus new or under a waiver and not under a waiver. It is very challenging to follow because we are talking about different variables all at the same time.

Director Hamos added that Mr. Pick hadn't even added managed care as another variable.

A: Ms. Ellinger stated that we are all struggling in the same way as everything is moving so quickly and guidance from the feds is coming slowly. They know this because they are also struggling. Regardless of what we do with Medicaid, one of the most significant issues is this movement across the Medicaid threshold onto what will be the exchange in Illinois. Thinking about the exchange, people at that income level will virtually be fully subsidized by the federal government through a tax savings but only for a relatively basic plan. It is very likely that the Medicaid program could be richer than what they move to unless they somehow subsidize it themselves. The level of subsidy may be at 100% until income reaches 200% of poverty. Then it will tail-off until income gets to 400% of poverty. The subsidy will occur through the tax system. There's no easy answer to how you could move across that line in the least disruptive way.

Q: Ms. Kovach stated that we have to get legislators onboard for the Medicaid expansion. The Shriver Center has put out documents about how this Medicaid expansion is the best deal for the state. What is the director hearing about the legislators' biggest concerns that we can be addressing?

A: Director Hamos responded that she is not hearing anything real because we are caught up in this election. It isn't possible now to have anything but a partisan discussion. The big challenge for HFS is that legislators are looking down the road to see how much the state will be on the hook. Along with this, legislators will say that the feds are telling us you'll give us 100% but will they really stay with that commitment. Legislators will be worried about the long term liability for the state and will ask about the benefit plan. These are likely the two biggest concerns.

Q: Chairperson Gordon asked that if the Access subcommittee were going to take up this discussion about the benefits, what would be the right time for that discussion.

A: Director Hamos stated that if we were going to do this internally through the subcommittee, we should use the next six weeks to inform ourselves of what is potentially included, the trade-offs, the options and what are the issues. The biggest challenge in working through this process and getting this new Medicaid population onboard, her biggest concern is who is going to serve these clients. Where are the providers?

Dr. Pont added that it is very important to have continuity between the plans so providers can understand what they can do for their patients.

Chairperson Gordon would like to see this discussion taken up in the Access subcommittee.

V. Review of Amendment to MAC Bylaws

Mr. Pick read the proposed amendment which adds a new Section III, Vision Statement, to Article I of the Bylaws.

Mary Driscoll made a motion to revise the new section to read as follows: "It is the vision of the MAC to ensure that populations covered under HFS' Medical Assistance programs have timely access to quality care that meets their need regardless of factors such as race/ethnicity, primary language, geography or age". The motion to amend the amendment was seconded, voted on and accepted

A motion was made and seconded to accept the amended Bylaws. After discussion, a vote was taken and the amendment approved unanimously.

VI. Review of Access Subcommittee Charge

Chairperson Gordon referred to the revised charge for the Access subcommittee that was included with MAC meeting materials and had been approved at the July 20th MAC meeting.

VII. MAC Access Subcommittee Members

Chairperson Gordon stated that the MAC is continuing to look for members to serve on the subcommittee. She stated that there is a survey being sent to everyone who has indicated an interest.

Dr. King commented on the issue of amending the Bylaws. She asked what is the meaning of this change if you can't ask HFS to have that same agenda. This MAC was not able to ask the department to have a racial justice or social justice agenda. She stated that it was her insistence that the issues be put on the table and voted on. Putting these things in the Bylaws was only a reaction to that. The question is how we push the agency to have the same kind of agenda. We're talking about who may be on the Access committee. We need to look at who has voice on all of these committees.

Ms. Ellinger responded that the Bylaws state in the second meeting of each year, the MAC will review the charge and membership of each subcommittee. This also could be done at anytime or meeting. So there is a responsibility and expectation for members to review these things. It can be raised as an issue if anyone is unhappy with the subcommittee composition. But again it is the will of the body. The body acted this way in reaction to what Dr. King had raised. We expect that the Access subcommittee will be reviewing issues and identifying things to recommend to the department. But the committee is advisory. Dr. King raised a significant issue and it is on paper now.

Director Hamos added that speaking as the director, we would very much welcome and really need your help in recruiting people of color to our committees to make sure we have balance and have the perspective of the people we serve.

Director Hamos stated that we decided to move forward rather quickly with this conversation about the expansion of Medicaid through the Access subcommittee. She asked how we plan to set up the subcommittee meeting and if the first meeting could be in mid-October.

Chairperson Gordon advised that setting the meeting date was dependent on getting the survey work completed with persons interested in serving and getting out the appointment letters. Assuming this can be done in the next few weeks, the first subcommittee meeting could be scheduled for mid-October. Suggestions for members of the subcommittee should be sent to HFS staff, Andrea Bennett at andrea.bennett@illinois.gov or to Chairperson Gordon or sgordon@luriechildrens.org

At Judy King's request, Ms. Ellinger described the Access subcommittee survey. It uses a questionnaire to collect demographic data about race/ethnicity, geographic location that person may be representing and areas of access interest. The purpose is to ensure diversity and distribution on the subcommittee. No one is obligated to complete the survey but it is required for appointment consideration. The information is not shared and only used internally for committee selection. She noted finding representatives for downstate, especially for southern Illinois can be more difficult.

The group had additional discussion on the survey methodology.

VIII. Approval of MAC 2013 dates

Chairperson Gordon referred to the handout of proposed MAC meeting dates for 2013. She noted that the dates are on Fridays but change to Thursday for the September and November meetings. A motion was made and seconded to accept the 2013 schedule. The proposed schedule was voted on and approved unanimously.

IX. Subcommittee Reports Open to Committee

a. Long Term Care (LTC) Subcommittee Report
The September 14th meeting had been canceled and so there was no report.

b. Public Education Subcommittee Report
John Jansa reported that the committee met on August 9. Frank Kizner of the Illinois Dept of Insurance (IDOI) discussed the final report from HMA on the Navigator program design. An essential finding was that while there are still a lot of details to work out, there is a consensus for a block grant approach to support these efforts. This program is the piece from the ACA to assist individuals to engage in and make selections in the insurance exchange. There was some concern expressed regarding how we are going to reach so many people statewide and about how the Navigator role would carry over if there were other issues or challenges like being dropped off an insurance plan. The report can be found at: http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommisions/MAC/News/Pages/080912.aspx Mr. Kizner advised that he could attend future meetings to provide updates as this project is ramping up.

There was an ACA update regarding the status of the health benefits exchange in Illinois. It would be a federal/state partnership model that has HFS, IDOI and the feds working to ensure state certification and would require legislation.

There was an update on the Integrated Eligibility System (IES), the state of the art eligibility system that the state is undertaking. It was announced that Deloitte Consulting was recommended to receive an award to work on the IES development. CSG Government Solutions will be given the project management component. There is still a need for HFS to procure the independent verification vendor to do quality assurance. The goal is to have a basic version of IES in place by October 2013 with a start date for the complete eligibility system of January 2015.

The committee began the discussion on what the IES would be called. One suggested name was the Application for Benefits Enrollment or A.B.E. Other suggestions are welcomed.

There was an update by Lynne Thomas, All Kids Bureau Chief, on changes in the All Kids enrollment since July 1. About 28,000 parents lost eligibility for FamilyCare under the SMART act when the income standard was reduced from 185% to 133% of poverty. Children with income above 300% of poverty that were grandfathered in last year also lost eligibility as of July 1. All Kids staff members are making sure that parents have a chance for review for an accurate determination of eligibility.

Ms. Ellinger advised that she doesn't know how many parents have reenrolled. Women of children bearing age with income below 200% of poverty are automatically enrolled for Illinois Healthy Women for 3 months and may apply for an additional 9 months.

Mr. Jansa stated that at the last meeting there was a public involvement statement that the committee was given the chance to edit. The statement is a call to the general public to make them aware of the opportunity to participate in MAC committee meetings. There was a deadline for the middle of September to comment.

Ms. Ellinger added that this development of a statement was first raised at the Public Ed subcommittee. The committee made a lot of changes and the department appreciated the comments received. The public involvement statement is scheduled to be mailed with all medical cards at the end of November.

X. Update on SMART Act 2840

James Parker, Deputy Director of Operations, reported that HFS has filed reports with the medical legislative advisory group monthly. There were some 60 some measures that HFS was required to do and had filed a large set of emergency rules back in the summer. The Joint Committee on Administrative Rules (JCAR) has suspended 7 of those rules for various

reasons on a wide range of areas such as hospital required conditions, ambulance transportation and the 4-script limit. At the last JCAR meeting, HFS agreed to changes that have most of those back in place and is implementing them.

HFS is trying to put things in place to start measuring some savings. It is a little complicated because there are so many different cuts and measures. There are a large number of utilization controls that overlap with pharmaceuticals that make it difficult to tell which change is saving the money. Some savings are very clear. As mentioned, there were some people who were removed from the roles in July. There also were rate cuts that took place. There will be some more emergency rules coming forward in the next few months. We have some rules that are still suspended that we are working on a solution so we can get them through JCAR.

Mr. Parker took questions and some key points are summarized below.

- The antibiotics rule that was rejected came out of the 4-script rule. The rule was re-filed without antibiotics as an exempt class. The provider notice last week that listed antibiotics as not requiring prior approval went out while the exemption was still being reviewed. HFS is looking at approving antibiotics for short-term use and prior approval only if prescribed for long-term use.

- At the dental policy meeting there was a motion made to ask that the universities in Illinois with dental schools be exempt from the limits on the health network. HFS may only spend $60 million on adult dental services. There will be attempts to tweak the law but HFS is not in a position to change the law. HFS is making a list of places where people would benefit from tweaks in the law and will potentially be able to work with the legislature on doing some changes.

Dr. King expressed concern that the two-step process for approving adult emergency services could impair access further.

- It will be difficult to know how the SMART act it is going without timely claims data. What could happen is that by the time the department gets the claims data in we will be into the spring legislative and not know how this is really going to come out. How the department is doing will impact the changes that advocates and provider groups want to restore some of the services that have been cut. The legislature will be looking at how HFS is doing in getting to our cost-saving targets. It is going to be very challenging to put that data forward next spring and know that we haven't got to those targets in many areas.

Chairperson Gordon advised that unless anything else on the SMART act, she wished to go to the next agenda item.

- Dr. King stated that she would like to make a motion. She referred first to Public Act 096-1501. Ms. Ellinger advised that this law is not the SMART act. Chairperson Gordon advised that that would actually be a new business item and asked if Dr. King would wait until then to make the motion.

- Dr. King made a motion that HFS and IDHS should seek emergency approval to restore medical assistance benefits to adults previously covered under the state-funded General Assistance program. The state should resume and continue to provide medical assistance until the Cook County "1115 Waiver" is authorized or until 2014 when this group of adults will be eligible for Medicaid under the Affordable Care Act.

Chairman Gordon asked if there is a second to the motion. There was not. The motion did not carry.

- Dr. King made a motion that the MAC recommends that HFS establish a Drug Utilization Review 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 Medical Society is lacking in transparency. Illinois is the only state without a public DUR and P and T review process.

Dr. Pont seconded the motion. He asked if the state's current drug therapeutic committee is transparent or not.

Mr. Parker responded that not UIC but the State Medical Society provides a Drug and Therapeutics Committee to the department. Parts of those meeting are open and parts are not. There was a lawsuit last year about whether the meeting violated the Open Meetings Act (OMA). The ruling of the court was that it doesn't violate the OMA. That committee is not the DUR committee. The department has appointed a DUR committee which is a totally separate committee in compliance with federal law. The committee is working to get out a report that federal law requires. He believed the timing for that is the end of this month or the end of October but not sure when that report is due. Mr. Parker did not know if the OMA applies to that committee. That committee is supposed to review data and file a report. He doesn't believe that it has any meetings that would be subject to OMA but stated that he is not an expert on that.

Ms. Driscoll asked who recommends drugs that would be on the Medicaid formulary.

Mr. Parker stated that in Illinois, we do not follow the formulary method that the Social Security Act requires. HFS is required to cover all drugs of companies that sign rebating agreements. By federal law we cannot cover the drugs of companies that do not sign the rebating agreements. The department does have a preferred drug list. That process is a two-step review. First, UIC has a contract that helps HFS develop recommendations for the list. That information is combined with our financial information. Those recommendations do go to the medical society's Drug and Therapeutics Committee.

Dr. King stated that she had filed a FOIA request a year ago and again a few months back. She asked for the minutes of the DUR committee and was told there was no DUR committee in Illinois. The question is will HFS make this a public committee so there is a forum for a lot of these issues on the SMART act could be discussed.

Mr. Parker responded that the DUR committee was reconstituted as a result of her inquires.

Dr Pont made a motion to move to table Dr. King's motion until Mr. Parker reports back on how the DUR committee operates to better determine if there is transparency. The motion was seconded and approved by the MAC.

XI. Update on Care Coordination Initiatives Discussion of Subcommittees

a. Innovations Project

Mr. Parker reported that proposals for Care Coordination Entities (CCEs) for the Seniors and Persons with Disabilities population are in hand and the department has been reviewing them. An HFS review committee has been meeting weekly with the final meeting this afternoon. The department hopes to be making initial awards by the end of next week. Mr. Parker wanted to emphasize that the selection process is not "all or nothing". The initial awards do not mean that a bidder that doesn't get a reward next week will not get an award in the future. HFS is trying to pick the best and most ready proposals that are fundable and move forward. The department has limited capacity to try and implement all of them at one time so expects to award a handful of those at the beginning of next week.

b. Dual Medicare/Medicaid Care Integration Financial Model Project

The department has the dual capitation proposals in hand and would hope to announce the awards in the next week or two. HFS continues to be in discussion with the federal CMS on the final shape of the dual capitation plan. HFS is also working with the other demonstration states on some of the issues that have come up. The department is tentatively scheduled to begin these programs on April 1, 2013.

HFS recently had a meeting to discuss the CCE solicitation for complex children and had asked to get feedback by September 28th. After that feedback, HFS hopes to get that solicitation out in the beginning part of October.

c. 1115 Waiver Demonstration Project

Mr. Parker stated that HFS is working hard on that but he is not directly involved with the development. He believed that the department and Cook County Health and Hospital Systems are looking at a November 1 start date.

Ms. Ellinger added that Theresa Eagleson is now on a call with Cook County and the federal CMS negotiating. We are in the final stages of nailing down the terms and conditions that the feds apply to approve the waiver. Cook County is still working to put all the pieces together on how people will apply and developing the network. The Department of Human Services is working very hard on establishing capacity to determine eligibility under the waiver because that is a new set of rules. All of those pieces are getting worked on simultaneously.

Q: Matt Collins asked about the capitation project. Will the state of Illinois be moving forward with plan selections without a Memorandum of Understanding (MOU) from CMS?

A: Yes. On the duals, HFS will make the announcements but it is all contingent on CMS approval. The target for the MOU is no earlier than December 1 and perhaps later.

Q: Shari Lewis asked a about the Innovations project. **1)** Is the department still on track for to award 10 in the city of Chicago and 10 south? **2)** What is the criterion for selection?

A: 1) No. That was going to be our maximum when there were initially 85 letters of intent. HFS is treating this as the federal Medicare/Medicaid Innovations center dealing with proposals before them. The proposals come in and they make rolling announcements. They select some and put the rest to the side. That is how the department expects to go on. The

decision making is based on who is ready to start and who has the best proposals. This is the first time out. The department would like to work with some of the proposers to see if we could work on something for the next round. **2)** The criteria were included in the proposal.

Q: Nadine Israel asked about the approval of CCE proposals that will be announced. Is the expectation that they will be off the ground on January 1, 2013?

A: It would be great if the department could do it. This is our expectation at present.

Q: With the announcements of the awards, is HFS taking into consideration that there is going to be a need for an opt-out for the Medicare portion of the dual solicitations? Will the department make sure that ground workers and caseworkers enrolling individuals tell clients that the options for CCEs or MCCNs are available to them versus the auto-assignment process that is happening now?

A: Opting out is only a duals issue. When the duals opt out of the Medicare portion, the CCEs are a potential option for the individual to opt onto. HFS is looking into that.

Dr. King made a motion that the MAC sends a letter to CMS requesting approval of the Cook County 1115 waiver. She stated that former general assistance clients lack medical coverage and could be enrolled for benefits under the Cook County waiver with CMS approval. The motion was seconded and there was discussion supportive of sending the letter.

The motion was called for a vote and was approved with all members in favor. The department would draft the letter for Chairperson Gordon's review and signature.

XII. Open to Committee

Kelly Carter stated that she was sad and upset about the attacks on the department that had been made at the press conference the director had referred to. She wanted to thank HFS staff for all the hard work they have done.

Ms. Ellinger stated that she is not hearing the voices out there saying that clients have due process rights or that nobody should lose benefits to which they are entitled. She stated that she is speaking for herself only. We have people's rights to protect here and have that obligation.

Chairperson Gordon asked if there is anything that people would like to raise for discussion at the next meeting. Member provided suggestions that included:

- Allocate a certain amount of time for each agenda item for the next meeting or discuss this at the next meeting
- Review of the PCCM program and the external reports for all the voluntary managed care plans. Include looking at all the measures for the individual voluntary managed care plans.
- An update on the enhanced eligibility verification (EEV) system.
- An update on the Affordable Care Act

Ms. Ellinger announced that the Public Ed subcommittee is meeting again on October 12. The committee asked to meet with our vendors. We may be able to meet with a Maximus representative then. She suggested watching for that agenda if interested in attending.

XIII. Adjournment

The meeting was adjourned at 12:05 p.m. The next meeting is scheduled for November 16, 2012.