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

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

Members Present
Susan Hayes Gordon, Chairperson
Mary Driscoll, DPH
Kathy Chan, IMCHC
John Shlofrock, Barton Mgt.
Judy King
Andrea Kovach, Shriver Center
Joe McLaurin for Linda Shapiro, ACHN

Members Absent
Eli Pick, Post Acute Innovations
Edward Pont, ICAAP
Glendean Sisk, DHS
Sue Vega, Alivio Medical Center
Renee Poole, IAFP
Jan Grimes, IHHC
Karen Moredock, DCFS

HFS Staff
Julie Hamos
James Parker
Jacqui Ellinger
Arvind Goyal
Robyn Nardone
Kim Wagenaar
Mercy Sanchez
Mike Murrill
Sally Becherer
Sherri Salada
Sameena Aghi
Andrea Bennett
Jennifer Partlow
James Monk

Interested Parties
Frank Anselmo, CBHA of IL
Victoria Bigelow, Access to Care
Dave Bibrey, Meridian Health Plan
Brittan Bolin, Vertex
Chris Breitzman, Family Health Network
David Brinn, JUF/JF
John Bullard, Amgen
Sherry Cantway, AHS
Mary Capetillo, Lilly
Kelly Carter, IPHCA
Wendy Carver, IlliniCare/Centene
Christine Cazeau, IHC
Carrie Chapmen, LAF
Gerri Clark, UIC-DSCC
Laurie Cohen, Civic Federation
Mathew Collins, Health Spring
Mike Cotton, Meridian Health Plan
Danielle D'Alessandro, Strickland & Assoc.
Thomas Erikson, BMS
Andrew Fairgrieve, HMA
Gary Fitzgerald, Harmony-Wellcare
Claudia Forrest, Maximus
Eric Foster, IADDA
Paul Frautz, Well Care
Pat Gallagher, ISMS

Interested Parties continued
Amber Gartner, Byram Healthcare
Donna Gerber, BCBSIL
Susan Greene, Consultant
Dean Groth, Pfizer
Marvin Hazelwood, Consultant
Lee Hennigan, GSK
Joe Holler, IHA
George Hovanec, Consultant
Teresa Hursey, Aetna
Marissa Kirby, IARF
Margaret Kirkegaard, IHC, AHS
Jeff Knappen, Allergan
Michael Lafond, Abbott
Phillip Largent, Consultant
Dawn Lease, Johnson & Johnson
Dave Lowitzki, SEIU
Randall Mark, CCBHS
Molly McAndrew, Heartland Alliance
Sarah Mearns, GSK
Dennis Majeskie, Johnson & Johnson
Mora Martin, PHRMA
Grace Martos, Molina Healthcare
Mickey McEntee, ICEB
Susan Melczer, MCHC
Diane Montañez, Alivio Med Center
Heather O'Donnell, Thresholds
Melissa Picciola, Equip for Equality
Ena Pierce, Healthspring
Jennie Pinkwater, ICAAP
Jay Powell, Amerihealth Mercy
Patricia Reedy, DHS
Carla Robinson, Consultant
Sam Robinson, Canary Telehealth
Phyllis Russell, ACMHAI
Dee Ann Ryan, UCMHB
Amy Sagen, UI Hospital & HS system
Bonnie Schaafsma, IAPHA
Jay Shattuck, Shattuck & Assoc.
Bernie Stetz, Molina Healthcare
Johnathan Thombeni, Byram Healthcare
Erika Walton, Maximus
Sharon Ware, Maximus

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

I. Call to Order

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

II. Introductions

Attendees in Springfield and Chicago introduced themselves.

III. Approval of September 21, 2012 Meeting Minutes

Dr. Judy King asked that references to the Drug Utilization Review Committee in the Update on SMART Act 2840 show the acronym DUR not DRU. She asked that the following sentence be added to the discussion points regarding the SMART Act on page 7 after the second dot point: "Dr. King expressed concern that the two-step process for approving adult emergency services could impair access further". With this change, the September minutes were approved.

IV. Old Business

Cook County 1115 Waiver Letter

Randall Mark reported that the waiver was approved on October 26, 2012. This consummated a two year process. The negotiations with the federal CMS intensified after the Supreme Court decision in June upholding the Affordable Care Act. Final terms and conditions were negotiated just the month prior to approval. The key items that took the most effort were the budget authority, and the per member per month payment. The eligibility screening process requires first screening the applicant for traditional Medicaid before being considered for the waiver. The last issue negotiated, were the terms around retroactivity and how that would work for the County. Now the really difficult work begins.

Susan Greene began by stating that her consulting firm had been chosen by Cook County Health and Hospital Systems (CCHHS) to do the preliminary operational implementation for this waiver. She stated that the waiver involves an enrolled population in a closed network. The County is building the infrastructure to operate as a health plan. At this point, two vendors have been secured. The enrollment vendor, Chamberlin Edmunds, has always been with the County doing Medicaid eligibility and their role has been expanded. Within the Cook County Health System and perhaps other County facilities, they will be doing enrollment in "OnPoint", the County's IT system that will have an interface with IDHS. The County has promised to make complete and accurate determinations. The only way for a person to apply is through the County. Another vendor, Automated Health Systems, will perform back office functions like managing member services, provider relations, operating a call center, claims payment, referral tracking, utilization, and satisfaction surveys. This is the company that operates Illinois Health Connect. We also issued an RFP to supplement our primary care network as some of the hardest appointments to get in the county network are for adults. The waiver will allow us to expand services to the adult population. We are in the process of hiring several hundred people to roll-out a patient centered medical home model that we already have at four sites. The County is in a clinical transformation to a patient-centered medical home model.

Under the waiver, CCBHS has issued an RFP and selected 13 FQHCs to handle their own enrollment utilizing the OnPoint system to first start enrolling their own patients then open it up for enrollment for the entire county. Today CCHHS will post RFPs for a behavioral health manager and a pharmacy benefit manager. In the next couple of weeks, we will issue an RFP for hospital and specialty services as well as diagnostic services. We are interested in the safety-net hospitals that have a commitment to this population. On December 1st, we will have a full service call center. Our website has an FAQ section with some information about covered services. It is anticipated that the HFS system will be ready to accept our applications in December. We don't expect to have members until January or February, depending on the State's processing time frames.

Q: What is the Cook County website? **A**: http://cookcountyhhs.org/

Q: When did you say the hospital RFP would be out? **A:** There is no set date but soon.

Q: Regarding the behavioral health manager, is that for one entity to do behavioral health?
A: CCHHS is interested in having one behavioral health manager that will have a network of providers for all the services. We have specified that one of the criteria is the willingness to have a broad network of providers and provider types.

Dr. King's motion about the Drug Utilization Review (DUR) committee

Dr. King clarified that at the last meeting she had made a motion that was seconded. She is disappointed that her motion is not on today's agenda. Her motion is that the MAC recommends that HFS establish a DUR committee consistent with federal law and compliant with the Illinois Open Meetings Act. She added that 65% of medical assistance beneficiaries had a claim for a prescribed drug in 2010 and that 12 of the policy changes called for under Public Act 97- 689 involve pharmaceuticals yet there is no public space where experts, pharmacists, practitioners, and others may survey, review, and make policy recommendations on drug use. She stated that the HFS Drug and Therapeutics committee managed by the

University of Illinois and the Illinois State Medical Society lacks transparency and that Illinois is the only state without a public DUR and pharmacy & therapeutics review process. Her concern is transparency. If a topic is not on the agenda people won't know that it will be discussed.

Chairperson Gordon advised that James Parker, Deputy Director of Operations would provide an update on the Department's DUR committee. She added that at the last meeting, Dr Pont had made a motion that was seconded and approved to move to table Dr. King's motion until Mr. Parker reports back on how the DUR committee operates.

Jacquetta Ellinger, Deputy Director of Policy Coordination, clarified that Mr. Parker's report is responding to Dr. Pont's motion and it is not necessarily addressing Dr. King's motion on the table. This is the report called for in the minutes.

Mr. Parker stated that he would give a brief description of what HFS does regarding drug utilization review and distinctions among the different committees. If there is something HFS needs to put on the agenda for next meeting we can do that. HFS has the drugs and therapeutics (D & T) committee and the DUR committee. The two committees have different functions.

The DUR committee is staffed by individuals at the University of Illinois at Chicago and is tasked by federal law with reviewing drug utilization and looking for aberrant prescribing patterns, prescribers that don't seem to be following best practices, looking at issues such as drug interactions and in cases where it seems appropriate, intervening with prescribers to discuss. It is not the policy making arm of coverage or other things. The committee is manned by Dr. John Tulley, Dr. Rachel Caskey, and PharmD's Lori Wilken and Anitha McGellie.

The D & T committee is a committee of the Illinois State Medical Society with members appointed by the medical society with services provided free of charge. HFS uses this committee to review coverage decisions such as new drugs on the market and whether the drug should be controlled by prior approval because: the drug may be abused; the drug may be seen as something that may be used as a 3rd or 4th line drug for a certain diagnosis; it is extraordinarily expensive; or should only be prescribed by certain physicians. They also review HFS' recommendations for a preferred drug list. The list is organized within therapeutic class and based on negotiations with drug manufacturers in order to get the lowest net price. HFS makes recommendations on which drugs should be preferred and not on prior approval, and which drugs are not preferred and should be on prior approval. The committee reviews those decisions from a clinical basis.

Mr. Parker reminded the group that policy decisions under the SMART act are law. Neither committee has a role in deciding if those policies should be implemented. For example, the four-script limit is the law and not reviewed by the DUR committee or the D and T committee. It is only reviewed by JCAR when HFS sends rules through them.

Q: Mary Driscoll asked if everyone that sits on either committee has to declare conflicts of interest. She asked if declaration of financial interest statements like a physician has a relationship with a drug manufacturer are transparent and available.
A: Mr. Parker believed that they all complete an ethics statement. With the D and T committee, there is a form members must file indicating any relationship with a drug manufacturer. He wasn't sure what the Department asks from the DUR committee members, as their role is not about deciding which drugs HFS covers, but looking at patterns of utilization. He stated that declaration of financial interest statements should be available under the Freedom of Information Act.

Q: Chairperson Gordon stated that the MAC would be interested in knowing what the proper forum is to raise issues about drugs, for example in the SMART Act. Perhaps the Access subcommittee is the place to look at that.
A: Mr. Parker suggested the MAC or Access subcommittee as forums to discuss issues like the four prescription limit.

Dr. King stated that there is still a need to discuss the issues around prescriptions drugs in the SMART Act. She also wanted to know if her motion would be put on next meeting's agenda. She had a question about when the Illinois DUR committee was created as there are no meeting minutes available. She noted that the CMS website has DUR reports with attachments and that Illinois completed its 2012 report. She believes that people will see that the reports can be quite meaningful.

Chairperson Gordon advised that the motion will be included as an agenda item at the next MAC meeting.

Ms. King also referred to the web link: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Programs-Data-and-Resources.html

V. Ethics Training 2012

Shannon Stokes from the HFS Office of General Council reviewed the Ethics Training requirements for the MAC members. She stated if members didn't receive the ethics training packet or have questions that they didn't wish to ask now, to please contact her at shannon.stokes@illinois.gov. She stated that the ethics training must be completed by December 14th and it is OK to scan or email the Acknowledgement of Participation statement to her. She added that if a person is on two HFS committees, the form only needs to be completed once.

VI. Director's Report

Mr. Parker started the report and was later joined by Director Hamos.

Innovations Project and Dual Medicare/Medicaid Care Integration Financial Model Project

Within the last week, the state announced the six managed care organizations that will serve MMAI clients in the Greater Chicago area. These are Aetna Better Health, Centene, Meridian Health Plan, HealthSpring, Humana Health Plan and Blue Cross/Blue Shield. In the Central Illinois region the awardees were Molina Healthcare and Health Alliance.

He emphasized that Illinois does not yet officially have the MMAI demonstration award from the federal government but is working on the Memorandum of Understanding. When that document is signed by the state and federal CMS, we will have the program. HFS is hoping to get that done by the end of the year with a start date of September 1, 2013. The plans would begin serving persons who had voluntarily enrolled. Passive enrollment would not begin until January 2014. Persons would be assigned to a plan but may opt out to fee-for-service or another advantage plan. HFS is pursuing a waiver with CMS to mandate duals into managed care for coverage of Long-Term Supports and Services.

Director Hamos asked persons with the companies chosen as MMAI awardees to briefly introduce themselves. The following persons did so: Mathew Collins and Ena Pierce with Healthspring; Donna Gerber with BCBSIL; Michael Cotton with Meridian Health Plan; Wendy Carver with IlliniCare/Centene; Bernie Stetz and Grace Martos with Molina Healthcare; and Teresa Hursey with Aetna Better Health. Chris Breitzman of the Family Health Network also introduced herself. Her organization is one of the Innovations Project awardees.

Four-Script Limit

Mr. Parker stated that a lot of changes have been made to the four-script limit in the last month. At first, the Department had set the system claims processing edits to only reject claims if a person had more than ten scripts in a month. In October, HFS moved that down to eight scripts. Shortly thereafter, HFS was flooded with requests for prior approval and experienced significant delays in people trying to get through to the hotline or get requests in. HFS started to fall behind in getting requests processed. In response, the department did a number of things like remove children from the edit and move the edit to nine scripts for adults until after Thanksgiving. HFS has hired temps to work on data entry of faxed-in scripts, freeing up the operators to take more phone calls. HFS was getting a lot of calls to check on the status of prior approval requests. In response, the department created some online systems and a separate phone line at UIC to handle status requests. UIC has hired more people. HFS is creating an online system to check status. HFS has created a separate online system to directly enter prior approval requests. HFS is also creating a writable form on the website that will send the form to HFS and then HFS staff enters the data. HFS is data entering requests within a few hours and pharmacists at UIC are working them off in a couple of hours. The entire process is done within an eight hour day. HFS still believes there is a problem with calls not getting through which is why staff are directing as many people as possible to the online system.

Director Hamos commented that the four-script is not actually a limit. It gives the misconception that clients can't get over four scripts filled. It is really a prior approval process above eight scripts. HFS has found that the prior approval process provides an opportunity to look at a client's "total medication list". This process started as a budget exercise but has become a best practice exercise. HFS has found that some prescriptions are contraindicated and some are filled twice. The system is not perfect and perhaps in our care coordination world, HFS will be able to do it a little smoother. Dr Goyal has convinced us that while this process may be difficult in the long run it is about providing better healthcare to our clients.

Affordable Care Act (ACA) Update

Director Hamos shared that she had taken the job with HFS as the ACA had recently been passed in April 2010 and would be the next major social justice issue of our time. With the outcome of the recent election, we know ACA is the law of the land. Now ACA will move forward fast with a year and two months to implement it. There are two policy options in Illinois right now. These are creating a health insurance exchange and expanding Medicaid.

Illinois is submitting a blueprint to do a state/federal partnership exchange. It is not running its own exchange in year one. It will be up by next October to begin the enrollment process allowing people to apply for health insurance. Illinois is creating the Integrated Eligibility System (IES) that will hook into the exchange. Through the IES, people will apply for

health insurance. The system will allow persons to be considered for Medicaid or for private health insurance and eligibility will be determined for tax subsidies. HFS hopes there will a robust offering of health insurance available on the exchange. There will be an easy to use, consumer friendly website that will help applicants figure that out. There will be navigators that the federal government will contract with. Community based organizations should have the opportunity to contract for that. HFS was told yesterday that there will be an additional group of "assisters". There will also be a call center. If the state legislature doesn't pass a law for year two and beyond, the federal government will continue to operate the exchange.

HFS is also talking with legislative leadership about the next big initiative, Medicaid expansion. HFS estimates this market to be about 350,000 people who are not currently qualifying for Medicaid and tend to be childless adults. HFS anticipates about 500,000 enrollees with about two-thirds as new enrollees and the other third as eligible under the current Medicaid rules. HFS has to convince the legislature to give the authorizing legislation to get this done by rule. That is an agenda that HFS would like to move on right away. HFS is looking for member and participant help and advice in getting this done.

Director Hamos believes that Cook County will be a powerful coalition partner as it is building a new health network and coordinated care structure and the waiver is financially good for them. Under the waiver, the County receives a 50% match. Under the ACA, the county will receive a 100% match. If the legislature doesn't authorize Medicaid expansion, the Cook County match will be zero. All of us will pay for the uninsured using the County's safety-net hospital system.

HFS along with its partners and advocates need to develop a coalition right now. There will be a bill drafted that people can organize around. It will be very simple with three components in the bill. One is an exception to the moratorium limiting the expansion of Medicaid. Second the legislature needs to create the new category that covers persons 19 to 64 years old with income up to 133% of poverty. The third part is establishing the new Medicaid benefit package. This will be discussed in the MAC Access subcommittee on Monday but any feedback is appreciated. HFS doesn't know if the legislature will want to weigh-in on that and itemize that in state law or whether they are willing to let HFS do it by rule. The bill will basically just reference health benefits service package and it delays the itemization of it until there is a rule created around it.

Q: Regarding the legislation surrounding the exchange, could you explain what happens if the legislature doesn't pass a law to cover two years and beyond?
A: There is a deadline of May 31st for getting the legislature to approve an Illinois exchange. If the legislature doesn't act the exchange will be federal only. However a new development is that the federal CMS is now saying that states can come in with their own exchange at anytime.

Q: Do we know how many of the new enrollees that are old Medicaid, will be for people with disabilities versus parents?
A: The estimate does not include disability. HFS anticipates that most of these persons will be adults.

Q: How will it work when a person applies through the exchange and appears to be eligible for Medicaid disability?
A: Ms. Ellinger stated that staff members are working hard on the new electronic eligibility system that will support all of Medicaid and SNAP and TANF in a year. If Illinois does decide to fill in the Medicaid gap in coverage, the work that is done in the federal exchange will make determinations for people who are in the new eligibles group. It will take information but it will not make determinations for people who are seniors or persons with disabilities. The plan is that there will be a smooth sharing of information between the exchange and the State. An application may begin with the State then forwarded to the exchange or started by the exchange and then forwarded to the State. By federal law, people will not need to apply twice.

VII. EEV (Enhanced Eligibility Verification) project

Mr. Koetting referred to the handout, Illinois Enhanced Eligibility Verification Project Fact Sheet, dated 11/14/12. He explained that the project was mandated by the SMART Act. There is a need to provide more caseworker support as over the last five years the average caseload has increased by over 80%. The state has to be able to say that we have a program that has integrity in the determination of eligibility. Recognizing this, the SMART Act gave HFS the ability to hire an outside vendor and to expedite the process by waiving the procurement laws. The department now has a contract with Maximus Corporation which is represented today by accounts executive, Sharon Ware and Erika Walton.

Maximus is providing assistance to DHS caseworkers and not redetermining cases. They are using a series of sophisticated databases to enhance our ability to electronically verify people's resources. They are serving as extensions of caseworkers in tracking down or finding additional information. Their staff will contact clients when there is conflicting or incomplete information to make sure that the department has the best possible information available for our caseworkers. They will push this information through an internet portal to caseworkers who will make the final decision on continued eligibility.

Clients will retain all appeal rights. Maximus' role will be somewhat invisible as they use HFS letterhead and identify themselves as HFS on the telephone. They will serve as an extension and supplement for the existing casework population.

DHS is adding 200 caseworkers and will have a much more efficient way of processing the results of the information collected by Maximus. The plan is to get this started in January. Maximus intends to hire about 500 people that will include a robust call center located in Chicago. They are hiring now. It will be a lot easier for clients to get in touch with the Department. There will also be more internet and fax capabilities. The contract was signed in September. In the next couple of weeks they will do 1300 interviews and will have offered jobs by the end of this month.

Q: Has there been an estimate of the number of people this will take off of the rolls as a result of more scrutiny?
A: HFS doesn't know. Director Hamos added that as part of the SMART Act, HFS was asked to come up with $1.6 billion in cost reductions. The vendor assistance was one of the items with a big dollar number put next to it. There was not much methodology behind the number. HFS is not going to obsess about the dollar amount and is not working toward a goal of kicking people off of Medicaid. The goal is to get this right and to restore or maintain integrity for this public program.

Q: Will the 200 additional DHS caseworker positions be permanent hires or just temporary for this contract?
A: HFS believes that these are permanent hires. HFS is creating a central eligibility determination unit which will also become the basis for our centralized unit for the Integrated Eligibility System. A longer term plan for eligibility modernization is to create a system where eligibility is not so strongly tied to the local office but to have information that is digital and available so that people can enroll and update their status without coming into offices. The local offices will still be there, but we need to create this capability, and part of that is having a centralized unit to respond to people.

Q: Will stakeholders have an opportunity to review any of the protocols to be used by Maximus or the new hires at DHS?
A: Ms. Ellinger commented that this is all coming up really quickly. At the last Public Education Subcommittee meeting, concern was raised that people in complex situations would not be handled properly by Maximus. HFS is not changing but enforcing redetermination policy. The department is trying to make the redetermination process more streamlined and believes that clients will now be able to gain access that they are not getting today.

HFS will be interested in knowing if clients are having difficulty with the new process. HFS did ask the Public Education Subcommittee to give scenarios or situations that they were particularly worried about, but there wasn't much response. If there are particular circumstances that persons working with clients have concerns about, please let us know.

Q: What is the status of the integration with IDES on new monthly reporting requirements for businesses in January?
A: IDES is developing a new system that will support that monthly reporting. Larger employers who are required today to report electronically will have that requirement. IDES is preparing rules to phase in this approach. HFS expects this capability to be available for redeterminations before use at the front end. Some may know that the departments use IDES information already but it is collected on a quarterly rather than monthly basis. The plan is to implement in January.

Q: Where do we share concerns or comments on services for the undocumented?
A: Anyone can raise them in this forum or send comments directly to Ms. Ellinger at jacquetta.ellinger@illinois.gov .

VIII. Subcommittee Reports

Access Subcommittee Report
Chairperson Gordon reported that the subcommittee met on October 24th for a briefing on benchmark Medicaid requirements and options for the Medicaid expansion populations. Materials are available on the website at: http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommisions/MAC/News/Pages/102412_macaccess.aspx
HFS requested input from subcommittee members and other stakeholders about that package. The subcommittee will meet on Monday, November 19. The notice and agenda are on the website.

Dr. King commented that the meeting was not a legal meeting. She stated that it was her understanding that everyone that sits on a public body should take a course online about the Open Meetings Act. She stated that there is a tendency for people who sit on public bodies to rely on the agency to be the word on what is being done is right. She stated that it is all of our responsibility to be open and transparent.

Chairperson Gordon agreed and added that there was a commitment made at that meeting to share all the guidelines about the Open Meetings Act.

Long Term Care (LTC) Subcommittee Report
There was no one available to report.

Public Education Subcommittee Report
Kathy Chan reported that the EEV system was discussed and that the department is looking for comments on the special populations that might need some special handling when it comes to the verification and eligibility determinations.

The committee spent quite a bit of time talking about implementation of different pieces of the ACA and the SMART Act.

The next meeting is scheduled for December 13th at 9 a.m.

Ms. Chan wanted to bring special attention to the fact that the Public Education Subcommittee has had a couple of members fall off because they just have not had the time to participate. The Subcommittee will be conducting a call for new members in the next few months. For persons interested in serving on the Subcommittee, we would look for a commitment to attend meetings, as this is a very active subcommittee, in either Chicago or Springfield. Meetings are every other month and there is an opportunity to review agency materials. There is a call-in number if you are unable to attend; however Ms. Chan encouraged in-person attendance.

Q: Dr. King asked if like the Access Subcommittee, there is a requirement to complete an HFS survey to become a member.
A: Yes. There is the intention to circulate the survey to have a better sense of geographic location and populations that the potential member represents.

Ms. Ellinger clarified that the survey has been modified to explain what the Public Education Subcommittee does. She clarified that the response to the survey was not required and some people responded to the Access Subcommittee and chose not to give some information. She noted that if we only appoint people we know, then the Department is too narrow in its focus. On the other hand, the Department needs to have a feel for where people are coming from and do they understand what we are asking for. On that process, people were very thoughtful in telling us what their interests were and why they cared.

Dr. King responded that it was not very clear that responding to the survey was not required. She added that in the previous minutes approved there was a statement that completion of the survey was required.

IX. Update on SMART Act 2840

Mr. Parker stated that his previous comments covered what he wished to say about the SMART Act and Care Coordination Initiatives.

Dr. King stated that she has continued concerns about copays. She asked what thought has been given to how that is affecting access and utilization. The concern applies whether it is prescription drugs, or additional fees for use of the emergency room, or additional copays for certain services for Illinois Healthy Women.

Director Hamos restated that the question is about the copays and whether the Department really knows how it is affecting access. She noted that HFS knows that people are required to pay them so the Department deducts the amount from the payment that is sent back to providers who are responsible to collect them. She asked if there are providers present that can better give us feedback on whether the collection at point of service has been more or less aggressive. Are providers saying these are really low-income patients that can't afford to pay and then don't attempt to collect the copays?

Joe McLaurin from ACHN responded that his organization is not going to go after the copays. The thinking is with the costs involved is it really worth it to collect?

Kelly Carter from IPHCA stated that HFS is inappropriately taking the copayment out of a lot of the members' payments. She advised that there has been some discussion with the Department about program changes. She added that some of the FQHCs are struggling with whether or not to charge and what to do when folks can't pay. Under federal requirement the FQHCs are supposed to collect the copays.

Heather O'Donnell from Thresholds stated that her organization is collecting stories about the effect that collecting copays is having on access and whether or not people we serve are able to afford the copays. We are also collecting stories on the four-drug limit and the effect that has on access. She can share these stories with the Access committee of which she is a member. She believes a number of providers are doing the same thing. She advised that Thresholds is collecting data as well as stories.

Dr. Margaret Kirkegaard stated that Illinois Health Connect has received a lot of feedback from providers about the copayment issues. There are some patients that are unable to make the payment and it leads to some fights at the front desk when patients are trying to register. There is a lot of concern from providers that they are stuck in the middle with a policy that they should be enforcing because their payments are being reduced yet there is also a federal requirement that they should see patients. There is also some misunderstanding about who should make copayments for what visits because it is a little complicated as to the requirements.

Dr. Kirkegaard stated that in her clinical environment, they have not always enforced the collection of copays because it may impair access to care. She works in a residency clinic and about three-fourths of the patients are covered under Medicaid. She noted that from a methodological standpoint, we can count the barriers to care that have happened but that will undercount those patients that just won't come to the doctor's office because they don't have the copayment or were embarrassed the last time they were at the office. There must be some other mechanisms for evaluating this issue.

Another person commented that from a plan perspective, we deal with a lot of providers. We hear a lot about the difficulty of collecting or not collecting copays. We do call campaigns just to get patients to come into the office. A high percent of providers are very astute about billing for the copay but not vigorously pursuing the collection of copays.

Another individual commented that their plan will make the copay on behalf of the patient. The plan recognizes that they are charged with collecting the copay and recognize that the copays are a barrier to care. As managed care begins to increase in Illinois, many of the health plans take the perspective that they will cover the copay for their members.

Dr. King stated that one of the issues of the SMART Act is to improve birth outcomes. She wished that there was a forum to review this. She had noticed that there was a quality meeting where the latest HEDIS measures for frequency of visits for ongoing prenatal care and postpartum care was provided. She was concerned that there has been little progress at least in the numbers for the managed care organizations. She questions whether some of the people should be recommended to enroll in some of the managed care programs that are currently serving low-income women.

X. Update on Care Coordination Initiatives

See IX, Update on the SMART Act.

XI. Open to Committee

Chairperson Gordon asked if members had topics they would like to add for future meetings.

- Andrea Kovach stated that Dr. King's comments about copays and bringing it to the attention of the MAC is very important. She is not sure that the topic would be adequately discussed at the Access subcommittee. She made a motion to add for the next MAC meeting, an agenda item to discuss further the copay provisions of the SMART Act to elicit feedback from providers as to what issues their patients are experiencing as far as copays. The motion was seconded.

She noted that the Shriver Center has addressed the copay issue with HFS and is concerned about copay issues in the SMART Act. For example, there is ER copay for non-emergent issues. If the patient does have an emergent issue in the ER and they are directed to an FQHC under federal law they are not allowed to be charged copay.

Dr. King would like to hear from providers, advocacy groups, and consumers about their experience with SMART Act mandated copays. She would like HFS to be thinking about what kind of data would show the impact of those copays. For example, are there less doctor visits by women as a result of the new copays in Illinois Healthy Women program?

Ms. Ellinger suggested that perhaps MAC members could be charged with representing their constituencies. For example, Ms. Kovach could come prepared to discuss what the advocacy community is hearing. The audience members would also be able to participate. Mr. McLaurin or Ms. Diamond Shapiro may share the provider perspective. Ms. Driscoll or Ms. Greene might give the public health perspective. By doing this members would be charged to prepare to discuss their experience and it would give more depth to the discussion. The department would also share what it has on the topic.

Chairperson Gordon restated that the motion is at the next MAC meeting there would be an agenda item to discuss copay issues in the SMART Act and that members of the MAC will come prepared to present their constituents views about it. A vote was taken on the motion with six in favor and one opposed. The motion passed.

- Chairperson Gordon advised that there was some additional new business. She introduced Frank Anselmo, CEO with Community Behavioral Health Association of Illinois (CBHA of IL). Mr. Anselmo shared copies of a handout that included a cover memo, dated November 15, 2012, regarding "Achieving Better Outcomes More Efficiently and Economically Related to Adults, Children and Youth with Complex Behavioral Health Care Needs". Chairperson Gordon advised that the handout has already been shared with Director Hamos and Medical Division Administrator Theresa

Eagleson. She added that Mr. Anselmo would give a brief description of the handout and that it includes items that could be discussed by the MAC Access subcommittee.

Mr. Anselmo stated that the board of directors for CBHA of IL has identified some questions regarding behavioral healthcare services. Three of the questions have to do with the contracting that is going on under the integrated coordinated care initiatives. The fourth question has to do with the need to look at the complex behavioral health care needs of both adults and children to achieve better outcomes more efficiently and economically. The handout has been distributed for MAC member review. There were no additional comments at this time.

XIII. Adjournment

The meeting was adjourned at 12:05 p.m. The next meeting is scheduled for January 11, 2013.