ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Medicaid Advisory Committee

James R. Thompson Center
100 W. Randolph

2nd Floor, 2025

Chicago, Illinois

And

201 South Grand Avenue East
3rd Floor Video Conference Room
Springfield, Illinois

November 18, 2016
10 a.m. - 12 p.m.

Agenda

I. Call to Order

II. Introductions

III. New Business
   a. Behavioral Health Transformation Update – Teresa Hursey – Director Norwood

IV. Old Business
   a. Managed Care Transformation- Robert Mendonsa
   b. System Changes- Jaqui Ellinger

V. Subcommittee Reports
   a. Public Education Subcommittee Report – Kathy Chan
   b. Quality Care Subcommittee Report –Kelly Carter

VI. Approval of August 2016 Meeting Minutes

VII. Other Business

VIII. Adjournment

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee August 5, 2016

MAC Members Present
Kelly Carter, Illinois Primary Health Care Association
Kathy Chan, Cook County Health and Hospitals System
Arnold Kanter, Barton Management
Bill Dart, Illinois Department of Public Health, ex-officio
Janine Hill, EverThrive Illinois
Thomas Huggett, Lawndale Christian Health Center
Howard Peters, HAP Inc. Consulting
David Vinkler, Molina
Jan Grimes, Illinois Homecare and Hospice Council

MAC Members Absent
Tyler McHaley
Karen Brach, Meridian
Karen Moredock, Illinois Department of Children and Family Services, ex-officio

HFS Staff Present
Arvind K. Goyal
Shawn McGady
Elizabeth Diaz Castillo
John Spears
Mike Casey
Shawn McGady
Kelly Cunningham
Robert Mendonsa
Mashelle Rose
Catina Latham
Sylvia Lewis Ripperton
Michelle Maher
Embarina Mendiola

Interested Parties
Chris Beal, Oysuka
Daniel Johnson, University of Chicago
Daniel Fry, AFC
Anna Carvalho,
Tim Smith, MPAG
Sheri Cohen, Chicago Dept. Of Public Health
Lynn Seerman, Kaizer Health
Ramon Gardenhira, Aids Foundation of Chicago
Rachel Reichlin, County Care
Mike Triana, Amerihealth Caritas
Priti Patel, Greater Elgin Family Care
Tiffany Askew, Access Living
Sharon White, Abbott
Maura Flanary, Field Health Care
Sharon Sidell, Be Well Partners in Health
Amy Sagen, UI Health
Rich Flores, Harmony Wellcare
Thomas Fisher, Next Level Health
Hetal Patel, Illinoiscare Health
Mike Holmes, Sunovian Pharm.
Heather O'Donnell, Thresholds
Christine Breitzman, FHN/CCAI
Virgil Tolbert, SASI
Keith Kindle, FHN
Laura Cohen, Civic Federation
Lia Daniels, IHA
Marsha Conroy, Aunt Marthas
Kim Burke, Lake County Health Dept.
Matt Petersen, Great Lakes Home Med.
Ken Ryan,ISMS
Gistavo Saberbein, Help at Home
Tiffany Ford, Health and Medicine Policy research Group
Julie Faulhaber, BCBSIL
Emily Shepp, BCBSIL
Traci Powell, Harmony Wellcare
Brian Keane, Aetna
Patricia Reedy, IDHS/DMA

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Meeting Minutes

I. **Call to Order: The regular quarterly meeting of the Medicaid Advisory Committee was called to order August 5, 2016 at 10:05 a.m. by chair Kathy Chan. A quorum was established.**

II. **Introductions: MAC members and HFS staff were introduced in Chicago and Springfield**

III. **New Business**

a. Behavioral Health Transformation Update – Kelly Cunningham

- Focused on health and human services, initiated under new administration
- BH effort is first focus of overall transformation effort
- Wide and broad plan that focuses on expanding programs, looking for opportunities for Medicaid financing, issues stemming from lack of coordination, lack of community capacity, duplication and gaps in service, lack of data analytics
- 1115 waiver – state plans to submit in early September
  - Will allow state to propose some innovative programs that may not be currently funded through Medicaid, seeking federal permission to move forward with innovation and creativity and obtain Medicaid financing
  - Engaged with consultants – McKinsey Consulting
  - Plan to submit in early to mid September
- Public hearings will take place in Springfield and Chicago – will have draft application posted prior to public hearings
  - Tuesday, August 16 in Springfield @ Howlett, 10-12:30
  - August 17 in Chicago @ JRTC, 9:30-12
- Waiver won't be the only mechanism to move forward with plans – will likely be complementary State Plan Amendments (SPAs) or other state authority
  - Intended to be comprehensive plan to look across spectrum of agencies providing mental health services
  - 13 cabinet agencies that have been part of transformation effort

See state's transformation website at https://www.illinois.gov/sites/hhstransformation/Pages/default.aspx - materials will also be posted on HFS website

b. Legislative update, Shawn McGady

- 150 pieces of legislation that directly concerned HFS
- Governor has until August 26 to sign or veto bills that HFS is tracking
- HB4351 – Gov vetoed last Friday – limited changing of DON score and department's ability to implement Universal Assessment Tool (UAT); bill goes back to House and Senatefor possible override

- HB5736 – extension of the All Kids health insurance act, signing celebration hosted by Healthy Illinois coalition, bill was effective June 30, 2016
- SB2332 – Requires HFS to establish procedures that pay LCSWs, 90 days to file rules; well on way to proposing rules for JCAR
- SR1916 – Requires HFS to conduct analysis of managed care to FFS costs, in process to collect information that will be shared with the Senate
- HFS is in early stages of legislative review process for 2017 – if you would like to work with HFS or get comments to avoid opposition, please contact Shawn

c. Budget Update - Mike Casey

- HFS has a budget that allows them to process bills for FY17 and do cleanup of administrative vendor bills for FY16
- With combination of court orders and approps bill – will be able to timely process Medicaid bills; some Medicaid bills will still require GRF and will likely be deleted awaiting cash flow resolutions
- $1.26B sitting at Comptroller – oldest bill sitting there is from May 26 (75-80 days old) from receipt for non-expedited providers and managed care
- Comptroller is working on paying some of May and all of June managed care billings
- July managed care billings, with exception of MMAI, were made last night (August 5)
- Through end of December 2016, HFS will be able to process bills, but not past December, since stopgap only include six months of operational funding

` **d.** Overview of Mental Health/Substance Use Disorder Parity Rules –

Kelly Cunningham

- Overview of MH/SUD parity rules – Kelly Cunningham will provide more information at the next meeting, since this is tied to BH transformation
- Background: 2008 Congressional legislation – Wellstone/Domenici Act – expanded early MH parity requirement to SUD benefits also parity in treatment benefits when compared to medical/surgical benefits; final rules were published earlier this year
- Final rules apply to Medicaid managed care plans, alternative benefits plan, and CHIP plans, but DOES NOT apply to those in FFS
- By October 1, states must be compliance with federal regulations – this is the work that is underway at HFS – want to make sure that this issue is addressed in overall transformation. IL is already ahead of other states, since BH is not carved out of MCO obligations in IL.

e. Bylaws: Proposed Changes - Thomas Huggett, MD

- Discussion about original amendment that circulated to members – opposition to prescriptive nature of type of providers that would be included in the revised bylaws and opens up the question of other providers to be included, e.g. dental, BH, etc.

- Dr. Huggett revised his request as a motion for the MAC "to advise the Director of HFS to appoint a PCP who serves IL Medicaid beneficiaries to each of the subcommittees of the MAC; advise HFS to require that that all subcommittees share written summary of the most important points of their meetings (not necessarily formal minutes) with full MAC for review at their meetings; with advise for MAC to review the progress of these suggestions six months from now." This motion was seconded and after discussion, adopted by MAC.
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IV. Old Business

a. Provider Enrollment Update – Mashelle Rose
   - August 31 deadline for providers to be in IMPACT for approval, ahead of CMS Sept 24 deadline
   - HFS has approved 25,000 new providers
   - Revalidated 70,000 existing providers
   - Still some in the system that need to be revalidated – reaching out to the individuals and to their associations
   - Close to 100,000 providers in progress that have not submitted applications, many are personal assistants, DORS and other waiver program providers; some may be atypical providers that never closed out of the system and who haven't billed Medicaid for years; estimated that 31,000 (of total 100,000) are medical providers that haven't submitted applications
   - After September 24, 2016, all providers must be revalidated (according to federal CMS); if not, HFS will make their account inactive, i.e. providers that have not been revalidated can no longer bill Medicaid

To contact Mashelle, email Mashelle.rose@illinois.gov

b. Managed Care Transformation - MLTSS Update - Robert Mendonsa
   - Managed Long Term Supports and Services (MLTSS) update – About 25,000-26,000 people in the Cook and Collar Counties are in MLTSS – Blue Cross, IllinoisCare, Aetna, Meridian are participating plans for MLTSS, which is for those in nursing homes and those obtaining waiver services
   - Sample member letters can be found on the CEB website; enrollment started July 1; by month end, 2,000 had voluntarily chosen; members get 60 days to actively choose a plan, if one is not chosen, the individual is auto-assigned, then 90 days to switch (same as choice period for ICP, ACA, FHP)
   - First auto-assignment to start September, completed by year end
   - MLTSS members are not choosing a PCP since this is just waiver services and nursing home

V. Subcommittee Reports
   a. Public Education Subcommittee Report - Kathy Chan *please see attached minutes
   b. Quality Care Subcommittee Report - Kelly Carter *please see attached minutes

VI. Approval of May 2016 Meeting Minutes

VII. Other Business

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a. Rede recommendations from workgroup that Dr. Huggett helped pull together (see below) – MAC agreed to adopt the recommendations and present to HFS to ask for their feedback by the next meeting in November * Please see attached document below

b. EverThrive and Shriver hosted a webinar earlier this month that featured HFS staff presenting on IES Phase 2 – recording of the webinar can be found at http://everthriveil.org/resources/starting-strong-webinars

VIII. Adjournment: Meeting adjourned at 12 noon– next meeting date: November 18, 2016

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Meeting Minutes of (date)

Quality Care Subcommittee

New Member introduced :

Barrett Hatchet – President/CEO of Chicago Family Health Center.

Discussion of Proposed Initial Quality Metrics: Asthma, Diabetes, Immunizations. A suggestion was made to the Subcommittee not to pick a specific metric but to look at all the metrics and see where HFS can move forward with their choice. Jennifer Cartland proposed creating an analytic plan that takes into account recommendations concerning access and network. Another recommendation was made by Jennifer Cartland that a small group get together to draft the analytic plan. The small group will circulate their results prior to the next Subcommittee meeting in September.

Amy O'Rourke of the Respiratory Health Association presented updates on the Coordinated Healthcare Interventions for Childhood Asthma Gaps in Outcomes Collaboration (CHICAGO II). Further updates will be provided at future subcommittee meetings.

Old Business: Robert Mendonsa reported: MCO and MLTSS roll out began 7/1/16. SmartPlan Choice ACE will merge with FHN effective Sept 1.HFS has been working with MCOs and providers to get payment issues behind them, making incremental progress. They had a meeting yesterday between MCOs and home care/hospice providers. Only quality results from CY2014 are available on ICP plans; HFS is in process of developing five star rating report that will be launched in the next few weeks (will be shared at the next quality care meeting); went from many quality measures to about 22 measures for FHP/ACA and ICP – reason HFS reduced the number of metrics was to make process more "consumer friendly" HFS will have CY2015 results for FHP/ ACA, and ICP in the next few weeks – will develop a five-star rating system ready in the fall; and this will be the basis for auto-assignment algorithm; Robert would like to come back to this committee and to other stakeholders on how to make this work; will require a fair amount of programming from HFS; hope to come to agreement by end of 2016 and implement by Q2 2017. HFS is currently tracking number of clean claims, but Robert doesn't think that this is a good measure; tracking another set of metrics such as pending claims, denials; it's possible that some of these will be include, but nothing has been decided

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Public Education Subcommittee minutes:

Care Coordination Update: In response to a request from committee members, Robert Mendonsa provided a report regarding HB6213. He said that the goal of this bill is to increase transparency and empower patient choice regarding Medicaid managed care. This will require each Medicaid Managed Care Entity (MMCE) to make available on the entity's website an accurate provider directory which must be publicly accessible and should not require passwords or user names. This will also require information to be easily understandable and in a searchable format so that patients can find healthcare professionals, hospitals, pharmacies, and facilities which provide services to Medicaid recipients under the MMCE plan. In addition, the MMCEs will be required to publish prescription medication formulary in their website. Mr. Mendonsa indicated HB6213 requires that the Client Enrollment Broker (CEB) publishes information regarding complaints, grievances, and appeals. The CEB must also include a toll free number and e-mail directory so people can report any inaccuracies. This requires making information publicly available regarding the Medicaid eligibility redetermination process and care coordination. Mr. Mendonsa indicated that during an upcoming meeting, HFS will introduce a consumer quality comparison tool to assist enrollees with Medicaid Managed Care Entity Plan selection.

Final Regulations/Consumer Education & Information: Kim Cox provided a summary of key provisions regarding the Federal CMS Final Regulations related to beneficiary education and information. She noted that this is the first CMS update to the Medicaid managed care rules since 2002. The main goal is to strengthen important protections for the Medicaid beneficiaries. She said that this vast document containing more than 6000 pages gives great flexibility so that states can build upon current resources. Members of the committee asked that the Department provide periodic updates about developments of how these rules will be implemented in Illinois.

Illinois Medicaid Redetermination Project (IMRP) Enhanced Eligibility Verification (EEV) Update: John Spears reported statistics regarding the redetermination process, which continues to be consistent with previous months, with the exception of the month of July, when a decrease in productivity was experienced, primarily due to staffing problems and computer issues that affected production. Kathy Chan asked if the report continues to be published on the HFS web site. It is and can be found at: https://www.illinois.gov/hfs/SiteCollectionDocuments/IMRPQtrlyReportQ4-FY2016.pdf Mr. Spears said that, on September 26, IES will take over the redetermination process. IES will begin generating October redeterminations forms. In a seamless process, the phones and fax lines will be transferred to the state. The central scanning unit and call center will also be staffed by state workers. It is expected that, by the end of December, the Maximus portions of the redetermination process will be terminated. amon Gardenhire indicated that, during the last Medicaid Advisory Committee meeting, a series of recommendations concerning the systematic redetermination flow were discussed. Nadeen Israel asked if the Department can provide an update about the reports that will be available upon launching IES

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Phase Two. Jacqui Ellinger said that although reports will not be made available to the public until January 2017, a preview of the format will be shared during the next meeting.

Client Notices: Jacqui Ellinger stated that with the launching of IES Phase Two, client notices will no longer be issued from the legacy system. Instead they will be generated by IES. She said that in response to the committee's request, copies of various client notices which will be generated from IES were distributed to members of the committee during the month of August. She reiterated the Department's interest in receiving any comments that could be taken to consideration for future changes. Jacqui Ellinger and Avery Dale discussed the rationale behind the design and structure of the notices with the members of the committee. She said the notices will be consolidated and that they are expected to be longer. For families with multiple benefits, SNAP information will be displayed first, followed by TANF, then medical information; the medical card will be the on the last page. In addition, with the launching of IES Phase Two, clients will be able to have access to the "Manage My Case" function in the ABE portal. As a result clients will be able to receive electronic notifications. However, individuals will continue receiving paper notifications, unless they choose not to.

ABE/IES Update: Jacqui Ellinger reported that on September 26, 2016, the state of Illinois will be launching IES Phase Two, at which time DHS and HFS will begin moving operations from their legacy computer system to the new Integrated Eligibility System (IES). Concurrently, the ABE portal will make "Manage My Case" available through which clients will be able to set up an account and track their applications, report changes, upload documents, file an appeal, and complete a redetermination. She said for new applicants an application has to be registered by a case worker before the client can link his or her ABE account to their manage my account. Ms. Ellinger also noted that in order to accommodate this transition, ABE will not be available from Thursday September 22nd until Sunday, September 25th. It is expected that ABE will be available for the public on September 26th.Jacqui described the ABE Partner Portal security enhancements that have been implemented with respect to All Kids Application Agents (AKAAs,) Medicaid Presumptive Eligibility (MPE,) and other medical providers which are subject to new security requirements in order to continue using the ABE Partner Portal.

Application Processing: Ms. Ellinger indicated that the Bureau of All Kids and the Family Community Resource Centers will only offer limited services on September 22nd and 23rd. However, they will accept paper applications. She said that only expedited SNAP applications will be processed on these days. Furthermore, the ABE Call Center will not take applications over the phone on those dates.

Criminal Justice Update : John Spears provided the criminal justice report. He said that HFS, DHS, and the Department of Corrections are currently working in partnership to develop a pilot project in the Department of Corrections (DOC). This pilot project is intended for individuals who are about to be released from either the DOC men's facilities in Illinois River or Danville, as well as one women's facility in Decatur. Sixty days prior to their release, DOC staff members will provide the necessary assistance to ensure that inmates submit an ABE application to request full medical coverage. Mr. Spears said that the Department of Corrections is taking the necessary steps to adapt its computer system to facilitate this

process. Certain FCRC offices will process these applications and ensure that appropriate protocols are establish, once the pilot proves successful and before its roll out across the entire state. Inmates will use the facilities' addresses for their applications and will report their community addresses prior to release to the DHS target office. Although inmate eligibility is restricted to in-patient hospitalization and related services while incarcerated, upon their release their benefits will be unrestricted. Sherrie Arriazola asked for an update regarding the developments of this project for future meetings as information becomes available.

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The MAC Public Education subcommittee
October 13, 2016

- Amy Harris provided an update on care coordination and announced that Health Alliance would no longer participate in the ICP or FHP managed care programs after December 31, 2016. Information about managed care for Medicaid enrollees is now available on the HFS website. An online complaint portal that medical providers can use to register concerns about MCOs will soon be launched.

- Mark Houston answered questions about the new Pharmacy Benefits Management System, which will be used to process pharmacy benefits for fee-for-service beneficiaries and will replace the current legacy system. The new system will allow providers to submit claims, submit prior approval requests, check real-time status of prior approval requests, and confirm client eligibility. HFS expects the new system to be up and running in 2017.

- Jacqui Ellinger shared that Phase 2 of the Integrated Eligibility System (IES) that was originally scheduled to launch at the end of September has been delayed.

- The committee requested that HFS provide enrollment and other data to help determine how well Medicaid clients are connecting with healthcare services. Committee members hope to review data to see if there are materials or communications that can be developed or improved upon to ensure that clients are properly educated about their healthcare options. HFS will respond to this request at the next meeting on December 1.

MAC Quality Care Subcommittee
November 1, 2016
10am-noon

Consumer report card (previous known as STAR report) – Catina Latham, HFS

- HSAG on the phone, external quality reviewer, which is required by CMS for all states with managed care in place
- Bureau of Quality Management and Bureau of Managed Care – to help consumers make an informed choice about managed care plan choice
    - Look at other states and national committee for quality insurance
    - Prepared internal mock ups of report card
    - Not many states have good models, but OH and MI also used HSAG
- SB6213 – HFS strongly supported since this was the direction they were going anyway
- Federal CMS released Medicaid managed care regs that requires states to create a consumer report card
- HEDIS (quality metrics) and CAHPS (consumer satisfaction survey) form the basis for the data collection and data sets
- Data will also be presented to MAC and to consumers (via FQHCs and their patients), as well as legislators
- Will get feedback from this committee, MCOs, and others on how to improve consumer health report card

January 2017 – the report that will be presented today
January 2018 – deadline required by SB6213, report will be expanded upon

HSAG – Ray, Senior Analyst (see presentation)

- Worked with HFS to design report card to compare plan performance during CY2015
- Reviews 10 ICP plans and 9 FHP/ACA plans – one combined report card, with exception of Keeping Kids Healthy measures
- Target audience is consumers – so meant to be easy to read to help them with plan decision making
- Two data sources: HEDIS and CAHPS – measurers used are grouped into categories to aid consumers
    - Use validated and audited data that is available
    - Use nationally recognized Medicaid or managed care data – HEDIS and CAHPS fits this
    - Categories include:
        - Doc communication/services - CAHPS
        - Getting care – CAHPS and HEDIS
        - Behavioral Health – MH/SU measures
        - Keeping Kids Healthy – FHP and ACA only
- Slide 5 describes methodology – HFS will provide full methodology guide once the approach has been finalized

    - FHP and ACA are weighted as one population – data was sent to HSAG as a single population
- Not all plans are NCQA certified, but all plans submit data to NCQA regardless
- Will be benchmarking to NCQA as well? Not for the report card, only comparing plans to each other.
- How were the measures selected in each of the categories? Which measures were being consistently reported by plans, internal consensus process and compared to what other states were reporting on
- Comment: So many plans are rating as average and they all end up looking the same, is there something that can be done to look at standard deviation so that plans can be differentiated
- Comment: Would like to see provider feedback incorporated into this report card. HFS says that is a different report card.
- HFS will eventually make this report card interactive so that consumers will only see the plans that are available to them.
- Why are there only two measures for BH? HFS says that they are only collecting two measures (of the 22 total) that relate to BH.

Quality Strategy Report - HFS will be posting quality strategy document online for comment by Friday – 30 day comment period. Required by CMS as a blueprint for states. HFS will email the members of the quality subcommittee when it is posted.

Auto-Assignment Algorithm, Robert Mendonsa, HFS – this only impacts those who are new to Medicaid and/or do not have a history with an MCO, as well as those who lost Medicaid because of rede and did not get reinstated in the two month period

- Current auto-assignment takes into account PCP relationship and also equalizing of enrollment among plans (i.e. Plans with lowest enrollment get preferential auto-assignment)
- Changing the latter to reward based on quality
- For this upcoming year, will be auto-assigning based on plans ability to submit encounter data
    - On a quarterly basis, plans report encounter data, validated against actual spending by plans
        - DASA, LTC, and waiver encounter data cannot be accepted by HFS
    - HFS is holding plans to 90% acceptance rate of encounter data submission
        - Some plans are still struggling, but lots of success; went from 50% success to over 80%
        - HFS has instituted penalties if the plans don't reach targets
    - There will be four bands and four categories of auto-assignment – similar for the first three – will always favor highest band
        - If PCP is in three plans, two of which are in band one, the auto-assignment will only be to the plans in band one
        - Band 4 will never get auto-assignment

- Plans in Band 4 will still have the opportunity to be chosen, just no auto-assignments
- HFS reinstatements (within 60 days) for Medicaid coverage does not impact plan choice/auto-assignment – would go back to the plan that the individual had chosen/been assigned to
- How would a provider know which band a plan is in? HFS needs to figure out a way to let them know.
- Discussion about updating the algorithm every six months (January and July)

MCO Performance Dashboard, Robert Mendonsa

- Tracking these metrics on a quarterly data
- Credentialing does not currently include time a plan takes to load the provider – that will be added
- Page 4 – Metrics from provider complaint portal – unresolved
- Page 20 – Payments/Claims – expectation that plans should work with providers that submit a high number of rejected claims

Timeline for posting? HFS wants to have it online by January 1, 2017 for data from July-Sept 2016. HFS will have a report for FHP in addition to ICP.

Is there any validation of the data that is self-reported by plans? HFS has not decided how to validate data. Suggestion was to report on how data was reported and whether the data is validated or self-reported.

Comment: Include the number of CAHPS surveys completed (N value) so that those reviewing would be aware what the result is based on.

Comment: Concern that no other states use encounter submission success rate (alone) for auto-assignment. Robert thinks that this is absolutely tied to quality.

The information about which MCOs are going to be in which band will be shared publicly.

How do performance metrics apply to dental MCOs? Credentialing would include dentists and all provider types, unless a specific service is mentioned. What about breaking out some of the metrics by provider type, including BH? Interested in getting additional feedback from stakeholders. Michelle Maher will accept suggestions/feedback about this.