ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Medicaid Advisory Committee

James R. Thompson Center
100 W. Randolph
2nd Floor, 2-025
Chicago, Illinois

And

201 South Grand Avenue East
1st Floor Video Conference Room
Springfield, Illinois

May 4, 2018
10 a.m. - 12 p.m.

Agenda

I. Call to Order - Chair
II. Introductions
III. Old Business
    a. Behavioral Health Transformation Update
        i. 1115 Waiver & Related State Plan Amendments
        ii. Integrated Health Homes
    b. HealthChoice Illinois Update
    c. Legislative Update
    d. Budget Update
    e. IES Phase II Update
    f. NB Status
IV. Subcommittee Reports
    a. Public Education Subcommittee Report
    b. Quality Care Subcommittee Report
V. Approval of February 2, 2018 meeting minutes
VI. Other Business
VII. Adjournment

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee February 2, 2018

MAC Members Present:
Karen Brach, Meridian/IAMHP
Kathy Chan, Cook County Health and Hospitals System
Arnold Kanter, Barton Management
Janine Hill, Soar Strategies, Inc.
Thomas Huggett, Lawndale Christian Health Center
Howard Peters, HAP Inc. Consulting
John Nunley, A Safe Haven (sitting in for Neil Vazquez-Rowland)

MAC Members Absent:
Tyler McHaley
Verletta Saxon, Centerstone
Glendean Sisk, Department of Human Services (ex-officio)
Neli Vazquez-Rowland, A Safe Haven
David Vinkler, Molina Healthcare

Ex-Officio Members:
Bill Dart, IDPH

HFS Staff Present:
Kelly Cunningham
Cheryl Easton
Arvind K. Goyal
Shawn McGady
Christina McCutchan
Paula O'Brien
Laura Phelan
Lynne Thomas

Interested Parties:
Alonzo, Alfred - Circle Family Healthcare
Arriazola, Sherri - TASC
Askew, Tiffany - Dept. on Aging
Beebe, Chole - AFC
Bell, Maria - Avesis
Borlage, Eric - Chicago Family Healthcare
Bowlby, Judy - Liberty Dental Plan
Boyer, Nick - Otsuka
Burke, Kim - Lake County Health Dept.
Campos, Blanca - CBHA
Carpenter, Leslie - HCCI
Chittaja, Emily - LaRabida
Cirrincione, Joe - Otsuka
Coleman, Dan - Merck
Conway, Marsha - Aunt Martha's
Cook, Simone - BCBSIL
Davis, Judith - BCBSIL
DeLeon, Sandy - The Ounce of Prevention
Echols, Jason – Age Option
Englete, Heather - ViiV Healthcare
Flanary, Maura - Shield Healthcare
Flood, Dana - Avesis
Foster, Eric - IABH
Frank, Paul - Harmony
Gordan, Susan - Lurie Children's Hospital
Hammoudeh, Matt - LSSI
Haney, Dionne - Dental Quest
Hellman, Talya - ACCESS
Hish, Daniel - Abbott Diabetes Care
Hong Duffin, Grace - KYC
Hosts, Cheri - IPHCA
Hurter, David - Presence Health Partners
Jansa, John - Smart Policy Works
Jones, Lorri - NextLevel Health
Kazee, Nicole - Erie Family Health
Kirchhoff, Amber - Thresholds
Klink, Don, VNA Health Care
Lafond, Michael - Abbvie
Larsen, Theresa - HSAG
Leonard, Carol - Dental Quest
Leonard, Danielle - Johnson & Johnson
Lindsey, Marvin - CBHA
Lulich, Amy - UI Health
Lundy, Ann - ACCESS
Maguire, Patrick - Medical Home Network
Malamut, Karen - Merck

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McCarrel, Deb - ICOY
McCoy, Sarah - IHCOP
Meek, Amy – ACLU of Illinois
Miller, Emily - IARF
Miskella, John - Melinta
Mortis, Phil - Gilead
Nelson, Julie - CSH
Newman, Sessy – EverThrive IL
O'Donnell, Heather - Thresholds
O'Rourke, Dru - ICAAP
Patel, Priti – Greater Elgin Family Care Ctr.
Pavick, Debbie - Thresholds
Pelayo, Livy - BCBSIL
Peterson, Matt – Home Products Healthcare
Pickens, Jessica –NextLevel Health
Pinkwater, Jennie - ICAAP
Powell, Traci - Harmony
Putz, Michael – Leavitt Partners
Ross-Senyah, Margaretta – Dept. on Aging
Ryan, Ken - ISMS
Schmidt, Elaine - IDCFS
Schubert, Ralph – UIC DSCC
Seermon, Lynn – Kaizen Health
Sellers, John - BCBSIL
Shatley, Katie – UIC – DSCC
Simpkin, Liz – Medical Home Network
Solinski, Jeanine – U Chicago Medicine
Sosa, Meryl – IL Psychiatric Society
Spivack, Felicia - Meridian
Suttan, Mikal - BCBSIL
Talley, Philip – IPHA
Thierry, Kate - HCSC
Tuten, Katie – Catholic Charities
Volante, Stephanie - IHA
Whitaker, Cheryl – NextLevel Health
Wilburn, Kuliva – Wilburn Strategic Solutions
Winnett, Cyrus - IAMHP
Wiseman, Lisa - Humana
Yannias, Cynthia – EQ Health Solutions

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee February 2, 2018

Meeting Minutes

I. Call to Order: The regular quarterly meeting of the Medicaid Advisory Committee was called to order February 2, 2018, at 10:00 a.m., by Chair Kathy Chan. A quorum was established.

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

III. Election of new Chair and Vice-Chair: Kathy Chan gave a brief overview of the voting process. Each candidate nominated by the Nominating Committee of the MAC was asked to give a brief summary of their qualifications. Dr. Huggett talked about his experience and why he should be selected as the Vice-Chair. Howard Peters also gave a brief summary of his skills and qualifications. Neli Vasquez-Rowland was also nominated for Vice Chair from the floor by Karen Brach. A motion to vote was put on the floor; elections were held: Howard Peters was elected Chair and Tom Huggett was elected Vice-Chair by majority votes. After the elections, the meeting was handed over to Howard Peters who thanked Kathy Chan for her service as Chair of the Medicaid Advisory Committee.

IV. Old Business

a. Behavioral Health Transformation Update

I. **1115 Waiver & Related State Plan Amendments** – Kelly Cunningham provided an update on the 1115 Waiver, and the SPAs; continued ongoing active discussions with Federal CMS. The Department is meeting frequently to work with CMS through all of the questions and requests. A lot of progress has been made to addressed some of their concerns.

There were a couple of questions from MAC stakeholders regarding work requirements and concerns if CMS was requiring that the State adopt work requirements in order to approve our waiver. It was shared that the Department was aware of recent dialogue at the federal level around work requirements but had no knowledge of CMS conditioning our waiver approval around adoption of such. It was also mentioned that in addition to work requirements, the federal government might impose other requirements like premium changes and Medicaid time limits.

Another MAC stakeholder also raised concerns about the CMS letter disallowing state's use of DSHPs, and asked for specifics regarding how waiver funding/financing was working absent DSHP availability. It was explained that the Department is working actively with CMS to mitigate this loss of funding while maintaining the integrity of our request and priorities.

Since the integrated health homes are so intricately related to the 1115 Waiver, inquiry was made on their status.

II. **Integrated Health Homes** – The work has been proceeding well, and we have had a really robust response from Federal CMS and from the Substance Abuse and Mental Health Services Administration (SAMHSA). Both of those federal agencies have to look at it and have to sign off on the integrated model in order for the state to adopt it. We have been told that Illinois' proposal is one of the most innovative one that they have seen in terms of integration of physical and behavioral health which is at the root of this transformation process. The Integrated Health Homes works a little bit different than the waivers. Basically the Federal Government wants everything nailed down prior to submission so we are in the final stages for getting everything ready to go. We really want the Integrated Health Home model to complement the transformation and what we are proposing to do with the waiver and state plans. We hope to keep both of them on the same track as we move forward.

Q: Is it the impression that, in terms of the Waiver versus the Integrated Health Homes, we are further down the tracks for an approval with regard for the Integrated Health Home plan than we are with the Waiver or do you think that they are on the same point in terms of getting approval?

A: I honestly think that we are kind of at the same point in terms of getting approval. We designed the two, to really work together. We believe that the process for approval is so different between the two models. The Integrated Health Home might have been a little quicker in getting out of the gate in terms of some of the earlier approvals from the Federal government, but it is such a different process it would be hard to compare it from a process perspective but we are absolutely working to design both of those programs to really fit together to meet the needs Medicaid beneficiaries in this state.

Q: I appreciate that you said for the 1115 Waiver that you weren't working on a work requirement, but I'm just wondering is there work being done on a separate waiver or something like that? I guess I am reflecting on what the Governor said at the Tribune Editorial Board (on Monday) that we have been working on it in our administration. So I am wondering if there is something else that is going on that's independent of the 1115 Waiver?

A: There has been dialogue at the federal level around work requirements but that I had no knowledge of CMS conditioning our waiver approval around adoption of such. There were questions from a couple of MAC stakeholders about work requirements and concerns that CMS was requiring that the State adopt work requirements in order to approve our waiver. I share that we were aware of recent dialogue at the federal level around work requirements but that I had no knowledge of CMS conditioning our waiver approval around adoption of such.

Another MAC stakeholder shared that in addition to work requirements, the feds might impose other requirements like premium changes and Medicaid time limits.

MAC stakeholders also raised concerns about the CMS letter disallowing state's use of DSHPs, and asked for specifics regarding how waiver funding/financing was working absent DSHP availability. I explained that we were working actively with CMS to mitigate this loss of funding while maintaining the integrity of our request and priorities.

Q: Do we have a timeframe? We have been asking about timeframe and it's kind of gone from November, to January 1st; now we're in Black History month. Where are we as far as timeframe?

A: We have been asking questions about the timeframe as well. You know we certainly would have liked to have had a much quicker approval from Federal CMS on this Waiver than what we have gotten. All I can tell is that we are in regular discussions with them. The State is working diligently trying to move this forward and unfortunately the approval timeframe is not under our control.

There is a working group that is working with an expectation that there will be a full implementation startup in June thru July. But as it was stated previously the Federal government will have to certainly approve it. The sense is that once the approval happens, we will be able to move into the implementation very quickly.

Q: Is there anything inconsistent with the 1115 Waiver versus the Integrated Health Homes?

A: No. The State has been very consistent about from the inception of this project about two years ago. The State is deeply committed to creating delivery systems that fosters physical and behavioral health and we believe that it is very important that all Medicaid beneficiaries in the state participate within an integrated health home to help coordinate that care. Nothing in our discussion with the Federal Government has changed that perspective. Actually it is intended to be harmony between the two in so far as in the Waiver itself there are actually incentive dollars to get provider groups to create integrated health homes; that's one of the reasons we hope to have them approved simultaneously.

Q: The prohibition on the designated state health programs DSHPs takes $200M a year out of the pot for the entirety for the state's portion of the waiver services. It seems like it would require a dramatic change in the way state is approaching the waiver in order to get these pilots up and running. I believe a dramatic change is in order. These pilots are very important. We have been waiting two years and we have put in a lot of our eggs in this basket. So what is important is how to make this work in this new landscape, but as far as I can tell it take a provider assessment or a GRF or the state putting real dollars on the table because getting the federal government to pay for state health programs through the DSHPs isn't going to work. Is the state willing to go there? Is that level of provision you guys are considering or can you share a little bit more about what DSHPs can provide: $200M+ a year to make these pilots work?

A: I don't have the answer to that question. This was something that we were not particular pleased about either. All I can say at this point is that we are working closely with CMS to try to maintain our priorities and look at some sources of funding within the waiver itself so reallocation may provide some dollars. I really don't know the specifics, but I can assure you that we haven't backed downed from our priorities or goals with this particular project. We are very dedicated to it.

Q: Howard, you were talking about IGH model moving forward possibly in July and we would like to know what we can do, as a health plan and other health plans to help prepare ourselves for what could be a rapid implementation by sharing what model the state has endorsed and what that would look like moving forward. Is that something you would be willing to share?

A: The Director and Teresa have advised that there is a real reluctance to have providers and plans start down a path before there is an approval because the negotiations with CMS could bring about some unanticipated change in direction as well as some of the things we just talked about like change in funding did. The Department would rather have the providers wait before we get too far down the path. That is the Department's official position. Wait until there are rules of the road before you go too far. The Department does plan to have interactive discussions with the providers. There will be opportunity for input as the implementation starts. The Department is cautious as not to send people off into a direction when the Department hasn't gotten approval.

Q: When you said implementation start-up in July, does that mean we will get the final documentation in July to start discussing what implementation look like? Or does it mean that actual implementation starts in July so we will have that information prior to that?

A: The hope is that we get an approval from CMS and that they start issuing documents with regards as to what the proposal would look like, what the qualifications by category would look like and begin to have those discussions both with providers, and the plans. The goal is to be ready once the implementation starts. The expectation is for CMS to have an answer soon.

Q: I think what would be helpful to the committee, would be a timeline. So I understand that we don't know when the approval is going to come but as health plans we could probably advise to say if the approval comes this day, it's going to take us three months to implement funding models, networks, etc., to put this in place so there is an opportunity for that kind of dialogue at least just to back into it, we need 3 month, we need 4 month, 6 months so that it's not a surprise and a rush. I know most plans would welcome that dialogue.

A: As an advisory group, I think I can speak for the committee that we certainly would advise the Department to give folks necessary notice and both the opportunity to help them to understand what is going to happen and implement it in a timely manner. I can also tell you based on the discussions that I've had with people at the Department I think there's a chance to do that. But since staff

is a part of this conversation, certainly Shawn and Kelly, I ask that that message be taken back to the Department.

Howard Peters stated that the Director has indicated both in this forum and as well as in legislative forums that the preference is to have both the waiver and the integrated health home plan amendment approved together and that if the waiver is not approved the Department does intend to move forward with integrated health homes. That has been her public record on this subject. I would assume until her public statement on that issue that is what we should anticipate. The importance of them being together as I mentioned already is that there are dollars in the waiver that have incentivized the creation and the development of integrated health homes; a state plan amendment does have the ability to be freestanding but with fewer resources.

b. HealthChoice Illinois Update – Laura Phelan provided an update

- Illinois Client Enrollment Services continues to be on track.
- Howard Peters requested that HFS release the VBP sections of the proposals for the awarded HealthChoice Illinois plans. He said this would help providers know each MCO's strategy and how to approach them. A MAC board member seconded his request, so Howard said it was a recommendation.
- An attendee asked if MEDI is more up-to-date than the REV vendor systems or if they are updated at the same time.
    - Kelly said that she believes the REV vendors are alternate sources of truths and update at the same time.
- An attendee requested the data the DCFS kids and MFTD waiver kids would roll into managed care. She did not think mid-2018 was an appropriate enough response. She said she if we don't have an implementation date now, she wants to know what date we will be able to give them an implementation date by.
- An attendee wants to know what date a draft schedule for trainings for providers will be available for the DCFS implementation.

HFS Care Coordination Update:

- The Client Enrollment Broker (CEB) is on track to continue to mail enrollment packets for the April 1, 2018 enrollment effective date through February 16, 2018.
    - At this time, we have mailed packets to about 343,000 of the 576,000 potential new enrollees.
    - In addition to the individuals who were in FFS as of 1/1/18, we are also mailing to individuals who become newly eligible for Medicaid.

  - The CEB receives a daily file with the newly eligible members and they will have a 4/1/18 enrollment effective date if the CEB receives their information by 2/16/18 and a 5/1/18 or later enrollment effective date if the CEB receives their information after 2/16/18.
- Many clients are calling the CEB to choose their MCO. Looking at the last few weeks: 4,900 clients, 5,900 clients, and 7,000 clients have called the CEB to select an MCO.
  - The CEB offers to check the MCO provider networks when clients call. The CEB has this information because it receives a weekly provider network file from the MCOs. Checking if providers are in network helps clients choose the MCO that will best meet their needs; just because a provider is in a Marketplace or employer plan doesn't mean that they will be in a Medicaid MCO's network, so it is important to check.
- Beginning the week of 2/19/18, the initial enrollment packets mailed the week of 1/15/18 will reach their 30-day enrollment choice period.
  - If no choice is made by an individual, their auto-assignments will kick-in. The CEB will check to make sure the PCP is still available when this occurs and will send the client through the algorithm if the PCP is no longer available.
  - The CEB will not send HFS this information until the client reaches their 30-day enrollment period without making a choice.

- Clients can switch one time prior to 4/1/18 (informal switch period) and one time after 4/1/18 (formal 90-day switch period).
  - If they switch during the formal 90-day switch period, the effective date of their chosen MCO will depend on when they call; the cut-off is mid-month.
- Because many clients are switching MCOs, providers should check a member's MCO using MEDI.
- While many clients are calling the CEB, average wait times have remained steady at 30 seconds with some spikes during high volume hours.
  - In recent monitoring, the longest wait time was 4 minutes and 40 seconds just after 8am. The contract requirements is an average of 7 minutes or less, which they have been meeting with the 30 second wait time average
- The Health Choice Illinois Auto-Assignment summary documents, with each plan's band and geomapping assignment rate, are now posted on the HFS Care Coordination webpage under FAQ. This is the same page that has the transition mail schedule.

- The general algorithm checks the existing PCP-member relationship, including consideration of an individual's family member, the existing PCP-member relationship based on claims data available, and geomapping.
    - The MLTSS algorithm is different because these members have Medicare and their PCP's are covered by Medicare. As a result, this algorithm checks the current long-term care facility, prior MLTSS plan, prior FHP/ICP plan, and geomapping.
- The bands are different in Cook County and Statewide because there are two additional MCO options in Cook County.
    - In Cook County, the band percentages are 55% for band 1, 18% for band 2, and 27% for band 3 plans.
    - Statewide, the percentages are 40% for band 1, 30% for band 2, and 30% for band 3 (which is split between two plans).

c. Legislative Update - Shawn McGady provided an update:
- Legislative Session has just began
- The Department does not have any plans to introduce legislation impacting the Medicaid program this session.
- If groups are introducing legislation that impacts the Medicaid program the Department would be willing to consider meeting to talk about the goals of the legislation.

d. Budget Update - Medicaid Bill Payment Status – Mike Casey provided an update:
- November 2017: HFS and Comptroller worked cooperatively to utilize a portion of bond proceeds and federal match revenue to liquidate over $4 billion in outstanding Medicaid bills.
- Prior to that point, the oldest bills for non-expedited fee-for-service providers and managed care entities dated to March 2017 (not all provider types were that old, however).
- After the buy-down, fee-for-service bills were essentially paid current into November and managed care into October.
- HFS and Comptroller staff have discussed cash-flow needs for the last six months of the fiscal year and each has committed to process and pay bills as soon as allowable with available state resources. Having said that, no payment cycle targets or guarantees can be offered.

Current status:
- Oldest fee-for-service bills at Comptroller- November
- Managed Care -November and January non-ACA capitations remain outstanding. December non-ACA capitations paid from a non-GRF fund.

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e. IES Phase II Update - Lynne Thomas provided an update:
   - IES Phase 2 was implemented on 10/24/17. Initial slowness issues were addressed very quickly and the system has been stable since then. Both new applications and case maintenance are now within one system.
   - Frequent releases and updates gone in to improve the system since implementation and that will continue. Workers are becoming more and more comfortable with the system every day.
   - The first rede cycle in IES was successfully completed in mid-January.
   - Manage My Case (MMC) now allows customers to not only file an application online but also manage their benefits.
   - 121,000 MMC accounts have been linked since 10/24/17, and 22,000 used MMC to renew their benefits during the initial rede cycle.

V. Subcommittee Reports

a. Public Education Subcommittee Report – The committee has met twice since the last MAC committee meeting. The minutes from this meeting are posted online. All future minutes will be available online at https://www.illinois.gov/hfs/About/BoardsandCommisions/MAC/publiced/Pages/minutes.aspx. The last Public Education meeting was held on April 5, 2018.

b. Quality Care Subcommittee Report – Ann Lundy gave a verbal report regarding the Quality Care subcommittee which last met January 9th; in addition Ann recognized new members on the Committee. Quality Care subcommittee has implemented a work group for implementation of long term services and support; this work group will report to the Quality Care Subcommittee and the full MAC. The objective of the LTSS work group is to improve awareness, to advise and make recommendations on ways to simplify interfaces between state agencies and other divisions in the LTSS community. Next meeting will be April 3, 2018.

VI. Minutes of the November 3, 2017 meeting - Approved.

VII. Other Business: Howard Peters suggested that if anyone has items that they would like to see on the MAC agenda to please forward them to Cheryl Easton at Cheryl.Easton@Illinois.gov. He asked that all requests be made 3-4 weeks prior to each MAC meeting.

Howard provided a quick update on Rules 132 and 140, sharing that another stakeholder meeting on Rule 132 would be scheduled for February 15 and that HFS was moving ahead with filing Rule 140 changes. A MAC Stakeholder was quite perturbed that Rule 140 wasn't on that agenda to discuss along with Rule 132. He explained that it was our belief that we had received and incorporated the extensive feedback received last summer.

VIII. Adjournment: Meeting was adjourned at 11:42 a.m. Next meeting is scheduled for May 4, 2018.