Illinois Department of Public Aid
Medicaid Advisory Committee

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

January 20, 2006

Members Present
Eli Pick, Chairman
Laura Leon for Robin Gabel, IMCHC
Susan Hayes Gordon
Diane Coleman, PCIL
Debra Kinsey, DCFS
Kim Mitroka – Christopher Rural Health
Ralph Schubert, , DHS
Neil Winston, M.D.

Members Absent
Pedro A. Poma, M..D.
Richard Perry, D.D.S
Robert Anselmo, R.Ph.
Alvin Holley
Nancy Crossman, DHS

HFS Staff
James Parker
Jacquetta Ellinger
Kelly Carter
Stephen Saunders, M.D.
Vicki Mote
Melissa Pop
Aundrea Hendricks
James Monk

Interested Parties
Tina Hartman, Healthpoint
George Hovanec
Kenzy Vandebroek, CDPH
Cher Beilfuss, Allergan
Ken Ryan, ISMS
Phyllis J Handelman, Handelman Consulting
Gerri Clark, DSCC
Lisa Gregory, IPHCA

Medicaid Advisory Committee (MAC)
Meeting Minutes

January 20, 2006

I. Call to Order

Chairman Eli Pick called the meeting to order at 10:15 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

Ethics packets
John Larsen from the Office of the General Counsel advised that 5 MAC members had not yet provided the annual Ethics statement. Follow up was discussed for each packet needed.

III. Review of the Minutes

September minutes were reviewed. Diane Coleman requested that her name be added to the list of attendees, as she was present at the last meeting. Susan Hayes Gordon moved to approve the minutes and Laura Leon seconded the motion. The motion was approved.

IV. Administrator's Report

Jackie Ellinger, Deputy Administrator for Policy Coordination, lead the report on behalf of Dr. Anne Marie Murphy. Ms. Ellinger stated that the three primary areas to report were: 1) Disease Management (DM) and Primary Care Case Management (PCCM); 2) *All Kids*; and 3) Medicare Part D. The report on Medicare Part D will be given under the "Old Business" agenda item.

Medical Advisor, Dr. Stephen Saunders, Contract Management Bureau Chief, Kelly Carter and Deputy Director for Operations, James Parker would assist in the administrative report. Ms. Ellinger added that there were no updates to report for the Springfield legislative session or the Hurricane Katrina relief efforts.

1) Disease Management (DM) and Primary Care Case Management (PCCM)
Dr. Saunders reported on the planning for the DM case management implementation. He stated that the Request for Proposal (RFP) went out on 12/23/05. A bidder's conference was held on 01/10/06. Responses are due back by 2/7/06.

There are 3 target populations for disease management coverage.

1) Disabled adults that are not dual-eligibles. This group may be institutional or community based and number over 100,000 persons. This population is expensive for the state.

2) Individuals with "persistent asthma" as defined by HEDIS and drawn from the family health population, e.g., children under 19 and their parents or caretakers representing about 48,000 persons. The State will ask the vendor to develop a cost survey for this subset.

3) Frequent ER (emergency room) users defined as 6 or more visits to the ER in a non-emergency situation. From the approximate 1.4 million persons in the family health population, there are about 15 to 16 thousand inappropriate ER visits. HFS wants the vendor to reduce the future number of inappropriate visits and provide a return on investment. The agreement is risk based with the vendor guaranteeing a minimum cost savings at 50%.

The disease management process includes identifying persons, completing a risk assessment and developing a care plan. Claims data will be available to the vendor. A nurse should complete care plans. The vendor is expected to: 1) work with the client or family member to better self-manage care; 2) work with medical providers to encourage appropriate treatment; and 3) share data and feedback to the doctors providing medical management, developing standards and reporting back on outcomes.

- Diane Coleman recommended that the department encourage vendors to look at and work with the peer support model used by Centers for Independent Living (CILs) in respect to the disabled participants not in the Medicare group.

Ms. Ellinger noted HFS was using peer mentors in a project designed to help persons with disabilities work.

- Ms. Hayes Gordon asked if the goal of PCCM and DM is saving $45 million.

Dr. Saunders advised that the primary goal is to create better quality of care. James Parker stated it is correct that department expects to realize savings but the amount is $57 million. The department expects net savings of 2/3 from disease management and 1/3 from PCCM. There is an expectation that the PCCM and DM vendors will work together, sharing information on who is the Primary Care Physician (PCP).

PCCM is a variation of managed care. Enrollees will include parents, children and disabled adults who are not institutionalized. Persons with Medicare will not be included. Person will choose their PCCM or be auto-assigned. The PCCM will provide a "medical home" with "24 –7" coverage. The PCCM will authorize hospital admission and specialty care.

The vendor must recruit an adequate number of providers. The vendor will recruit additional specialists including both pediatric and adult doctors. The vendor must take into account that the providers may choose patients and set a limit on the number of patients they will service. FQHCs. RHCs and health departments that meet the requirements may be PCPs.

- Ralph Schubert asked how the department sees other providers such as school-based clinics (SBC) fitting into PCCM.

Dr Saunders stated that direct access services could be used without referral. This would apply to SBC and health departments

- Ms. Hayes Gordon asked if the Division of Specialized Care for Children (DSCC) will have a role with foster children or children receiving Supplemental Security Income (SSI).

Dr Saunders stated that children in foster care or receiving SSI are not included in PCCM as their inclusion would require a federal waiver. These children have direct access to services and will not be assigned to a PCP. Other special needs children would be included. The department is looking at the possibility of specialists working as the PCP.

- Chairman Pick asked if the department envisioned a PCCM model that strengthens the patient–physician relationship by encouraging persons to choose a medical home already used.

- He asked if the department intended to create a new network. He pointed out that it is easier for a provider to work within an existing practice that includes a subset of Medicaid patients rather than establishing a new network or model.

Mr. Parker stated that the intent is to maintain existing patient-physician relationship, however, the department does not envision coming in with a new network. The goal is for more doctors to accept Medicaid patients and agree to sign a PCP agreement.

Ms. Ellinger added that PCCM will serve adults and children including some Aid to Aged, Blind and Disabled (AABD) adults.

Chairman Pick saw part of the challenge as looking at the market that includes a good number of doctors that are not seeking out new patients with Medicaid but have patients that have changed insurance from commercial to Medicaid.

He stated his experience is that if assignments are more burdensome, then specialists will leave. There are issues of low reimbursement and administrative hassles. There is a cost factor of completing administrative tasks. The key to success is maintaining the relationship between doctors and patients.

Mr. Parker stated that we are swapping one network for another – starting with Medicaid and then hoping to expand. The vendor will have several contacts with patients to make a choice and not be defaulted. The goal for the PCCM administrator is to come up with a user-friendly system.

The department is putting together a list of provider requirements and will share these with the MAC.

- George Hovanec asked if there is a future plan to do a waiver request to expand the covered population?

Mr. Parker clarified that any recipients who may be enrolled in managed care without requesting a federal waiver will be included in PCCM. There is no plan to seek a waiver to include more recipients under PCCM at this time. Ms. Ellinger stated that HFS may seek a waiver or state Medicaid or SCHIP plan amendments to obtain federal funding for persons made eligible with *All Kids* expanded eligibility. This is unrelated to managed care.

2) *All Kids*

Ms. Ellinger provided an overview and update of the new *All Kids* expansion to provide health benefits to uninsured children of any income level. Starting July 1, 2006, Illinois will cover all children who have been without insurance since January 1, 2006. There are some exceptions like providing coverage if parents lost job and health insurance, covering newborns and covering children in families that earned too much to stay in one of the current plans for children. All KidCare plans will be renamed to *All Kids* over the next few months.

The state wants as many children as possible to be enrolled effective July 1, 2006. For that reason, a pre-registration process has been developed. There is lots of community involvement in pre-registration. The pre-registration form is now available on-line in English and Spanish.

HFS issued an alert to KidCare Application Agents (KCAAs) renaming them *All Kids* Application Agents (AKAAs) and explaining how they could assist in the pre-registration process.

- What expectation is there that employers will shift their employee insurance to *All Kids*?

All Kids requires a significant period of not being insured to discourage employers and employees from dropping existing employer sponsored coverage.

- Does the on line pre-registration form allow the AKAA to be identified?

There is no place for the AKAA to be identified on the on line pre-registration form. AKAAs should assist families to pre-register on paper applications forms if the AKAA wishes to assist the family with the *All Kids* application when it is available.

- When a person with an existing case makes an *All Kids* application, must they go to the local DHS office?

Persons with existing cases wishing to add another family member need to contact their caseworker. The system is the same as today. The request to add a person goes to the place maintaining the case file.

- Will children in households with income over 200% FPL be excluded from the PCCM model?

Ms. Ellinger clarified that PCCM would be the model for services for most children, not just newly eligible children, as well as adults except for groups of persons who may not be mandated to enroll in managed care without a federal waiver.

- Ken Ryan asked if copays made in addition to Medicaid rates would be deducted? If yes, he recommends that the state reconsider this policy, as it is important in attracting physicians.

- Ms. Hayes Gordon reiterated Mr. Ryan's observation that copays deducted against the Medicaid rate is not a good idea.

Mr. Parker stated that the copay would be deducted from the Medicaid rate. He added that we could look at not deducting copays for certain services. Mr. Parker noted that there is a commitment for a 30-day payment cycle for physicians providing services to children.

Ms. Ellinger added that the department is not changing eligibility rules for currently eligible families. That is, eligibility criteria for families with income at or below 200 percent of poverty will not change with the exception that children will not have to meet immigration status requirements.

- Ralph Schubert asked whom school based clinics should talk to about the pre-registration process?

Ms. Ellinger suggested he call Gretchen Grieser who is heading up *All Kids* outreach for HFS.

Laura Leon added that March is awareness month for school based clinics and that the Illinois Coalition for School Based Clinics is working to ensure that correct information is available.

Ms. Ellinger reported that the department has selected GMMB to handle *All Kids* marketing. The marketing firm has done a lot of work with Covering Kids nationally and will be partnering with the Illinois Maternal and Child Health Coalition (IMCHC) to work on *All Kids*.

Diane Coleman advised that the Progress Center has a one-hour radio program serving all ages in the Latino community. This is a possible venue to reach families about *All Kids*. Ms. Ellinger promised to have someone follow-up on this offer.

V. Old Business

Medicare Part D. Mr. Parker stated that there has been a significant amount of confusion with the initial implementation. The good news is that implementation has been OK for the largest percentage of enrollees. HFS shifted coverage for about a half million persons and only five percent had problems. This is a small percentage but the number with problems is significant given that the overall population is so large.

There were two problems for the dual-eligibles. Some persons didn't know which Prescription Drug Plan (PDP) they were enrolled with and the systems that were set up to assist with this did not work well. HFS is working through these problems on a case-by-case basis. This has been time consuming.

A second problem for dual eligibles was that enrollment was switched in the system but the indicator that showed they were enrolled for the Low Income Subsidy did not follow. As a result, co-pays were much higher than appropriate. When no other solution developed, HFS established a process to allow recoding its database so the state could process pharmacy payments for these clients. Pharmacies were notified of this policy via direct contact or the Web site.

For the Circuit Breaker/SeniorCare group there were some of the same problems and we were able to recode showing no Medicare prior to January 1. There was a lot of confusion, so pharmacy education to allow Medicare billing was needed. We worked with PacifiCare to have an operational system.

The federal rules state that every patient has a right to a "transitional script" after January 1. There have been significant problems in implementation. It has been difficult for pharmacies to get paid at the regular copay. So patients saw very high, not regular, copays. We are working with the PDPs to honor the transition process fully.

HFS has redeployed staff to increase the number of people available to answer the hotline and assist clients. HFS has yet to see a significant decrease in problem cases but this may lighten up in the next week allowing better response times on the phones. On whole, pharmacies have been extremely cooperative. This is also true for the corporate headquarters of the pharmacy chains.

Ms. Coleman states that she is working with the Make Medicare Work coalition and believes that the department has done a wonderful job and was sixth in the nation to do a fix for those unable to get the prescriptions filled.

Kenzy Vandebroek added that the Chicago Department of Public Health (CDPH) is also happy that HFS did what it could to better serve clients.

KidCare/FamilyCare. Vicki Mote, Chief of the Bureau of KidCare, provided the committee with an update on the KidCare/FamilyCare program. She stated that the

KidCare Unit has spent a lot of time enrolling parents going from 133% to 185% FPL under the new FamilyCare standard. Next meeting she can report the increase in the number of covered parents.

There are about 2,000 pending applications. Complete applications are currently processed within 11 days. Enrollment data is provided for period as of November 30, 2005.

The web-based interactive application was implemented statewide on August 11. Since then, KidCare has received 10,530 web applications: 6,540 from the general public and 4,080 from KCAAs.

VI. New Business

1) Ms. Ellinger reported that Congress has agreed upon language for the budget reconciliation. The legislation is expected to be enacted shortly. It includes dramatic changes for the Medicaid program including Long Term Care asset rules and other changes effecting Medicaid reimbursement.

Among the most alarming changes is that, beginning July 1, 2006, states may no longer accept that a person is a citizen based on their declaration of citizenship. All persons will have to provide documentation of citizenship. At redetermination current eligible citizens will have to document their citizenship. Ms. Ellinger expressed concern that many seniors may be unable to provide information even though they are citizens.

There is no evidence that persons misrepresent themselves as citizens when they are not citizens. The effect of this policy change could be shifting a huge cost back on the state or the loss of benefits by many persons who cannot document that they are citizens. This will have a large impact on the provider community for payment for services especially nursing facility and other long-term care.

2) Ms. Ellinger stated that the department is looking at replacing the monthly Mediplan card with an annual medical card.

The annual card would be only an I.D. card, so providers would need to use one of the available systems to verify eligibility. There may be one card issued for each individual showing his or her name, birth date and RIN. The back of the card would include a telephone numbers for members and providers.

The annual card would be reissued not at redetermination but by zip code area. Persons could call for a replacement card and new cards would be issued for new individuals.

There was discussion on the increased burden on providers. Chairman Pick pointed out that the burden is no different than found with other health plans.

3) Chairman Pick stated that he had seen a copy of a notice for an RFP for non-emergency transportation under a single vendor. He had concern about the reliability and access if there is only a single vendor statewide.

Kelly Carter, Chief of the Bureau of Contract Management, stated that three bids had been received thus far. She advised that the experience in other states with a single vendor increased access. Initially other states got complaints from transportation providers, not medical providers. The RFP requires the vendor to provide access to all parts of the state. The vendor is expected to subcontract with a pool of existing transportation vendors working with the department. The result will be a provider network and not a single entity providing service.

Chairman Pick expressed concern about the reliability of the vendors showing up timely for pick up both before and after for appointments.

Ms. Carter started that there will be access standards and vehicle requirements. HFS working with the vendor can use the best providers and eliminate poor quality providers.

The plan is for July 1 implementation. It will be possible to enroll a private auto as a provider type.

VII. Subcommittee Reports

Long-Term Care (LTC). Eli Pick reported that the committee had met in December and discussed the Conference on Aging. Also discussed were 44 additional awards for Supportive Living Facilities (SLF). There are currently 26 existing SLF, including one for blind individuals. The committee did incorporate to allow for special needs individuals, including mental health.

Dental Policy Review (DPR). No report for this period.

Public Education Subcommittee. No report for this period.

Pharmacy Subcommittee Charge. No report for this period.

VIII. Adjournment

Chair Eli Pick adjourned the meeting at 12:02 p.m. The next MAC meeting is scheduled for March 17, 2006.

Medicaid Advisory Committee
January 20, 2006
KidCare/FamilyCare Report

Enrollment

- We have around 2,000 pending applications in the KidCare Unit. We are processing clean applications at 11 days.

- Enrollment data is attached. Enrollment data as of 11/30/05:

  a. 1,060,718 pre-expansion children (up to 100% of FPL)
  b. 354,164 pre-expansion parents (up to approx. 35% of FPL)
  c. 6,205 Moms and babies expansion (133% to 200% of FPL)
  d. 73,620 Phase I (100% to 133%) and 38,375 Phase II expansions (133% - 185% of FPL)
  e. 4,584 Phase III (over 185% - 200% of FPL)
  f. 30,788 FamilyCare Phase I (38% - 49% of FPL)
  g. 31,427 FamilyCare Phase II (49% - 90% of FPL)
  h. 47,656 FamilyCare Phase III (90% to 133% of FPL

FamilyCare Expansion

We expanded FamilyCare to 185% of poverty January 1, 2006.

Web-based application capability

We implemented our web-based application statewide on August 11. Since then, we have received a total 10,530 web apps: 6,450 from the general public and 4,080 from KCAA's.

Attachment 2
MAC - 01-20-06 Minutes

	5/31/2005		6/30/2005		7/31/2005		8/31/2005		9/30/2005		10/31/2005	11/30/2005
	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Previous Numbers	Current Numbers	Current Numbers	Current Numbers
Pre-expansion children	1,046,355	1,046,568	1,049,594	1,050,007	1,050,518	1,052,041	1,056,358	1,060,165	1,058,172	1,064,356	1,063,879	1,060,718
KidCare Phase I	66,490	66,499	67,647	67,669	68,804	68,904	69,825	70,158	70,569	71,155	72,522	73,620
KidCare Phase II	38,085	38,088	38,340	38,344	38,607	38,612	38,210	38,196	37,903	37,865	38,184	38,375
KidCare Phase III	3,531	3,531	3,710	3,710	3,865	3,864	3,991	3,984	4,179	4,176	4,342	4,584
Moms and Babies Exp	6,180	6,190	6,234	6,245	6,218	6,246	6,206	6,281	6,133	6,268	6,242	6,205
Pre-expansion parents	349,762	349,899	349,586	349,839	350,119	351,050	351,359	354,003	351,035	355,644	355,346	354,164
FamilyCase Phase I	30,513	30,512	30,790	30,795	30,958	30,969	30,993	31,023	31,020	31,050	30,960	30,788
FamilyCare Phase II	30,887	30,888	31,131	31,135	31,166	31,197	31,581	31,639	31,840	31,936	31,837	31,427
FamilyCare Phase III	40,795	40,795	42,402	42,409	43,752	43,795	45,046	45,127	45,996	46,153	47,102	47,656
TOTAL	**1,612,598**	**1,612,970**	**1,619,434**	**1,620,153**	**1,624,007**	**1,626,678**	**1,633,569**	**1,640,576**	**1,636,847**	**1,648,603**	**1,650,414**	**1,647,537**