ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
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Memorandum

DATE: November 9, 2011

TO: Members of the Medicaid Advisory Committee

FROM: Julie Hamos
Director

RE: Medicaid Advisory Committee (MAC) Meeting

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The next meeting of the Medicaid Advisory Committee is scheduled for Friday, November 18, 2011. The meeting will be held via videoconference from 10 a.m. to 12 p.m. Those attending in Springfield will meet at 201 South Grand Avenue East, 3rd floor video-conference Room B. Those attending in Chicago will meet at 401 South Clinton, 7th floor video-conference room.

Attached, please find the agenda for the meeting and the draft minutes from the September 16, 2011 meeting. As part of the department's ongoing efforts to reduce administrative cost, copies of the material will not be available at the meeting. Participants should plan on bringing their own copies.

The material has also been posted to the Department's Web site at:
http://www.hfs.illinois.gov/mac/news/

If you have any questions, or need to be reached during the meeting, please call 217-782-2570.

Medicaid Advisory Committee

401 S. Clinton
7th Floor Video-conference Room Chicago, Illinois
and
201 South Grand Avenue East
3rd Floor Video-conference Room
Springfield, Illinois

November 18, 2011
10 a.m. - 12 p.m.

Agenda

I. Call to Order

II. Introductions

III. Approval of September 16, 2011 Meeting Minutes

IV. Election of Officer Candidates

V. 2012 Meeting Dates

VI. Ethics Statements — Submitted to HFS by December 15, 2011

VII. Director's Report

VIII. Dual Medicare/Medicaid Care Integration Financial Model Project

IX. Subcommittee Reports
- Care Coordination Subcommittee Report
- Public Education Subcommittee Report

X. Open to Committee

XI. Adjournment

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Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
September 16, 2011

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

Members Present
Susan Hayes Gordon, Children's Memorial
Kathy Chan, IMCHC
Judy King
Jan Costello, IL Home Care & Hospice Council
Linda Diamond-Shapiro, ACHN
Andrea Kovach, Shriver Center
Karen Moredock, DCFS
Edward Pont, ICAAP
Sue Vega, Alivio Medical Center *via telephone*

Members Absent
Renee Poole, IAFP
John Shlofrock, Barton Mgt.
Melissa Vargas, AAPD Head Start DHI
Mary Driscoll, DPH
Alice Foss, IL Rural Health Assn.
Glendean Sisk, DHS
Myrtis Sullivan, DHS
Eli Pick, Chairman

HFS Staff
Julie Hamos
Theresa Eagleson
Jacqui Ellinger
Lora McCurdy
Sally Becherer
Ann Lattig
James Monk

Interested Parties
Mary Ellen Baker, MedImmune
Brittan Bolin, Vertex
Nick Boyer, Astra Zeneca
Kathy Bovid, ISMS
John Bullard, Amgen
Chris Burnett, IARF
Christine Cazeau, IHC
Carrie Chapman, LAF
Gerri Clark, DSCC
Mike Coli, iCare
Bob Currie, Aetna Better Health
Gary Fitzgerald, Harmony
Eric Foster, IADDA
Barbara Hay, FHN
Marvin Hazelwood, Consultant
George Hovanec, Consultant
Nadeen Israel, Heartland Alliance

Interested Parties
Tim Hennessey, Moline Health Care
George Hovanec, CMH
Paul Jagunich, United Healthcare
Margaret Kirkegaard, IHC
Keith Kudla, FHN
Michael Lafond, Abbott
Azmina Lakhani, SGA
Dawn Lease, J & J
Joy Mahurin, Comprehensive Bleeding Disorders
Susan Melczer, MCHC
Sharon Moloney, Meridian
Diane Montañez, Alivio Medical Center
John Peller, AIDS FDN of Chicago
Mary Reis, DCFS
Tobin Shelton, UIC
Jo Ann Spoor, IHA

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
September 16, 2011

I. Call to Order

Susan Gordon called the meeting to order at 10:05 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Review of the Minutes

Dr. Pont asked to add a statement on page 4, VI. Care Coordination Subcommittee report. He requested to add that Chairman Pick noted that the charge was so vast that the group uses it as a guide, but the subcommittee's focus should be on the first point which states the subcommittee will study ways to enhance the current PCCM program, Illinois Health Connect, to comply with the requirements of Illinois Medicaid reform law [P.A. 96-1501]. The minutes were approved with one abstention and this addition.

IV. Director's Report

Director Hamos stated that HFS is struggling through a tough budget year with a serious shortfall of $1.7 billion. HFS has developed the *Medical Assistance Budget Management Policies* document, dated August 3, 2011, (Attachment 1) that shows current strategies to address the budget shortfall.

Today, HFS will be meeting with the House Budget Appropriations Committee. The legislature wants HFS to use delayed payment cycles as a way to manage through the shortfall. HFS is trying to keep payments going to expedited providers who depend on those Medicaid payments, as well as payments to non-expedited providers. But, the comptroller is trying to pay off $5 billion in unpaid medical bills and has placed the department on a sort of "cash diet" — so HFS can't send all of the expedited bills at one time.

HFS is also releasing today a document titled *Medical Programs reforms, Efficiencies and Improvements Progress Report*, dated September 15, 2011 (Attachment 2) prepared for the House Appropriations Committee that shows 49 actions the department must implement pursuant to state law and federal policy. Director Hamos reviewed the chart layout. The department has created a Project Management Office (PMO), to be headed by Mark House. Mr. House will work with the progress report to turn the actions into deliverables. Our goal is to create the discipline to look at the time tables, accountabilities, responsibilities, and the different challenges and obstacles, so we can get things done, on time and on budget.

HFS is moving forward with the Care Coordination Innovations Project with the good work of the MAC's Care Coordination Subcommittee and Susan Greene. Ms. Greene is walking the department through a series of questions and complicated issues raised in the HFS white paper. Our goal is to launch the Innovations Project this year to incent community partners in creating some very innovative projects for care coordination.

The director mentioned that she had been invited by Congressman Danny Davis to Washington D.C. to appear before a U.S. congressional subcommittee, with 3 members of the Heritage Foundation, to talk about Medicaid. And, that at noon on the same day there will be a rally to save Medicaid.

Theresa Eagleson announced that HFS is moving forward with a "first glimpse" of the Innovations Project by holding a public meeting to be held on October 13, 2011, from 10:00 a.m. to 1:00 p.m., at the JRTC auditorium. She encouraged interested persons to attend. She advised the meeting participants that information on the meeting was posted on the HFS website.

Ms. Eagleson provided an update on the Integrated Care Program (ICP). Currently, almost 34,000 persons are enrolled in the ICP. The enrollment is almost equally divided between the two plans and the provider network continues to grow for both plans.

Ms. Eagleson reported that, as required under the Medicaid Reform law, the department is working at a technical level on hospital rate reform. The rates and payment methodology used to pay hospitals is critical to how we go forward with implementing care coordination. In addition, recommendations from the Governor's Nursing Home Safety Task Force, requires the department to look at an evidenced based way to pay nursing homes using the new federal assessment tool. Both are significant projects that HFS is working very closely with its provider groups to achieve.

Sue Vega asked if there is an updated list on the number of hospitals working with the ICP.
Ms. Eagleson advised that she didn't have a list, but knew there were about 50 hospitals with Aetna and 44 hospitals in IlliniCare. HFS will distribute/post updates periodically.

Andrea Kovach asked if the department has heard anything from CMS on their decision to allow active renewal in October of this year. Director Hamos advised that the department had not heard anything from CMS, but that Senator Durbin had written a letter to the CMMS director asking that he look favorably on the annual renewal plan and that it doesn't violate the Maintenance of Effort requirement. If CMS approves, it will be a challenge to implement the change by October 1, 2011.

Judy King advised of an ongoing concern about having outcome data available to the public. This would include who is being served, what services are provided and what the outcomes are. A lot of the talk is around care coordination and what HFS is going to do. How does the department know what it will do to respond to the problem? The MAC rarely talks much about health outcomes. So, if HFS is going to put out the Innovations RFP, is that something the department is going to share? What is the level of care that people are receiving and how do people plan to fix that? Over the years have been plans to fix, but the outcomes remain the same. This body and the department doesn't provide much information on age, race, language, other issues and certainly very little information or effort on who's getting care and what kind of care. This should be a priority action. Looking at the recent specialty care report was very painful, as HFS knows that kind of thing is going on.

Ms. King stated it was a shame that five years after Memisovski we wait for the report and this is reprehensible. There are a lot of things that are just being ignored. When she first raised concern about the dental services for children on Medicaid, and in particular the school system, children were not getting their services. The school system was supposed to report every year to the state board to show that children in kindergarten, second and sixth grades are having a comprehensive dental exam. That legislation came as a result of the expansion of Medicaid and put forth because of the idea that all children would have insurance so now we can require them all to have a dental exam. The state board sent up a system to track how many children are getting these exams and whether the barrier to get these exams is because they didn't have All Kids. You have a huge district like Chicago not reporting year after year. The data she has been able to get show only about 20% of those children were getting the exam. This year compliance has gone up. She sees a pattern where we don't look at the data and 5-10 years later there is a report and people say it is terrible that kids in Chicago are not getting their dental care. There are headlines and we see that things haven't changed. She asked HFS to report some of the outcomes publicly.

Director Hamos responded that there are still many problems that are yet to be fixed. The specialty care report which HFS cooperated with, and funded, didn't surprise any of us. Susan Hayes Gordon is an excellent advocate. A year after Memisovski, Ms. Gordon was telling legislators that we need to fund specialty care better. It came down to funding; and how you get specialist into Medicaid is better

funding. It is not that anyone is ignoring it, but we recognize that it's a big funding gap and not easily solved.

The director went on to say, that the department is taking data very seriously. She advised the group that a second person she has hired is an expert in data and research analytics. HFS is working to create an RFP that we can lay on top of our data warehouse, a new data analytics feature so we can have more timely data and fresher claims data. HFS went to the foundation community, who want to participate in care coordination and the Affordable Care Act, and asked for help in putting data together for provider groups, care coordination entities, MCOs and whoever else wants it to analyze it. Internally, we need to focus on the data you want and that really makes a difference. Our goal moving forward is to use data and data analytics to create a set of consistent reports that would allow us to track across providers to show what is really going on with our clients. HFS isn't doing a very good job at that, as yet, and we don't really have the capacity yet. If this advisory committee wants reporting on some things we do already have some things. The department needs some focus on what data the group wants. From a process standpoint, we want to provide this advisory group with data that is requested. The director shared that she was happy that Ms. King is at the table and reading the reports.

Jacqui Ellinger added that data is not necessarily information. It not only must be reported, it must also be manipulated and analyzed. There is no easy way to manage millions of records and make sure that they are correct. A lot of the work is going into making the reporting and the use of that data valid. If something is reported wrong, because of how the data is recorded, it doesn't help anyone. Ensuring the validity of the data is something the research director is working on.

Ms. King stated that she is having a hard time accepting what HFS is saying. There are some routine reports that the department makes to the federal government like the CMS 416, EPSDT report and the TIP annual report. These are standard reports and Ms. King is not sure why these are not posted on the Website. The provider profile reports from Illinois Health Connect are not available to the general public on the Website. She has yet to see a state summary of outcomes in a report with the state HEDIS measures. For example, provide data on the number of adolescents with a well child visit.

Ms. Eagleson stated the provider profiles are made available to individual physicians, but the department has to be careful as we can't disclose individual medical data. HFS is working on a data-book that would eventually be put on the Website. However, it is difficult to "mine through" all the data and make sure that we don't have any errors. For example, we had data that showed 3.6 % of the children had cancer and that just didn't seem right. Upon further analysis, it was discovered that there was a problem in data coding translation for an immunization code that is just one digit off from the cancer code. HFS must ensure accuracy of the data given to the public. We are happy to put out the federally mandated reports and to go beyond that and get more data out there by provider type and outcome measures. Ms. King was concerned that even under Freedom of Information Act (FOIA) requests; she has been unable to get county level data on race and ethnicity. She would like this on the next MAC agenda.

The group discussed prioritizing specific primary data needs such as HEDIS indicator outcomes and children's outcome data and that the foundation community might help with funding the data reports. Suggestions of who could assist in prioritizing data included the Public Education or Care Coordination subcommittees. Ms. Eagleson stated there may be more about the foundation community assisting made available at the Innovations Project meeting on October 13th, as well as an update at the next MAC meeting.

There was a motion to talk about data in the Care Coordination Subcommittee. The members approved to move discussion of data needs to the subcommittee with five approving, one opposing and two abstentions.

V. Appoint Nominating Committee to Select Officer Candidates

Ms. Gordon advised that the department has recommended three persons to appoint as a nominating committee to select MAC officer candidates. The nominating committee recommendations are Jan Costello, John Shlofrock and Andrea Kovach. The department is asking for the MAC members present to approve the slate. The nominating committee would work with HFS to name candidates and provide these names to MAC members before the November meeting to vote on. There was a motion to approve the slate. The motion carried with one abstention.

VI. Subcommittee Reports

Care Coordination Subcommittee Report

Dr. Pont provided the report. Participants were provided a handout, *Recommendations for Modification of the PCCM to comply with the Illinois Medicaid Reform Law* (Attachment 3). Dr. Pont walked through the following four subcommittee recommendations:

1. *Stratification of the monthly care coordination fee based on various clinical criteria*. The Department investigates other options to stratify the CCF based on practices' degree of adherence to the medical home concept.
2. *Improve Communication Between PCPs and Specialty Physicians*. The department encourages utilization of the MEDI portal and reimburses specialists for utilizing this portal. The state considers Cook County's IRIS program as an example of this type of functionality.
3. *Development of regional at-risk pools.* HFS establishes regional risk pools to distribute additional care coordination funds based on performance measures, i.e., ER utilization, hospital readmission, etc.
4. *Enhance utilization of current PCCM capabilities to optimize care across multiple settings.* HFS develops strategies to enhance utilization of: ER coordination utilizing the "Whose My PCP?" function; ICARE for immunization tracking; and the IHC appointment reminder function.

Ms. Gordon asked what the next steps are for the subcommittee. Dr. Pont advised that a next meeting date has not been scheduled as yet. He hopes to give an update at the November MAC meeting. Sue Vega asked if she could obtain a copy of the persons that attended the Tuesday Care Coordination meeting. Dr Pont advised that yes.

Ms. King is concerned with the statement, "By any reasonable standard the PCCM has performed admirably." She stated that HFS or the committee needs to substantiate that with data showing successful outcomes. Dr. Pont responded that the charge of the subcommittee was not to evaluate PCCM, but to see if PCCM could be enhanced to meet the criteria to include it in the 50% requirement as a coordinated care entity. He stated that he could modify the wording or replace with supporting statistics, but to keep in mind that the MAC created the subcommittee with the assumption that the PCCM was worthwhile.

The discussion was closed with Ms. Eagleson commending Dr. Pont personally, as well as the work of the Care Coordination subcommittee. The department recognizes their efforts and would like the committee to continue. She appreciated Dr. Pont's comment on the MAC minutes clarifying that the first charge of the subcommittee was to make recommendations on how the PCCM might fit into the care coordination standard. But, the charge of the committee is broader as well and the department would like the opportunity to come back at the November MAC meeting with some more concrete items for the committee to look at in its' broader mission. For instance, some things that are related to outcome data like: What sort of populations might benefit most from care coordination? What should the department measure across different systems of care coordination? How to risk adjust for a population and performance across plans?

Public Education Subcommittee Report

Kathy Chan and Andrea Kovach reported. The last meeting was in August. There was discussion about the CMS denial for changes in income and residency verification. The subcommittee also talked about other procedural and program changes, such as, the All Kids hotline doing address changes for callers with case files at local FCRC locations. While this may seem small, many of the application agents were very happy to hear about this as it helps get accurate information into a client's file.

There was discussion about the eligibility system for healthcare reform. It is taking place at the same time as the Health Benefits Exchange and the Legislative study committee providing recommendations for the fall veto session. A report is due to the general assembly by September 30, 2011. There have been three meetings so far and the next meeting is October 20, 2011. It will have a packed agenda including the items just mentioned. We also hope to get an update on the durable medical card.

The Public Education Subcommittee now has an established schedule and will be meeting every other month. The schedule is posted online. Anyone is welcome to attend these meetings. Ms. Kovach added that HFS envisions the EVE system will also at some point integrate other public benefit programs such as SNAP and possibly TANF. She recommended looking at the attachments from the last meeting.

VII. Open to Committee

Ms. King asked to hear from HFS about what is happening with mental health services since mental health providers are now billing through HFS. The department may have information about the level of services and kind of services that people are receiving. She also wanted to review whether or not persons with mental illness were getting primary care services. She noted that MAC members had received this data before but didn't have a chance to talk about it.

Ms. Eagleson stated that since the beginning of fiscal year 2012, the bills from community mental health providers are being submitted to HFS. However, the department is still working with the Division of Mental Health (DMH) and its' contracted value provider options to try to test that system. HFS is holding claims, but is working daily and diligently with DMH and its' billing agent to turn the system on. DMH has been sending out some advance payments and providers are receiving payments for FY11 claims, as the lapse period continues through December. The money doesn't actually shift to HFS' budget. It remains with DMH in the DHS budget and HFS is simply the claims processor. It will help us to coordinate the data better.

Ms. Eagleson asked if MAC members have a consensus that there be a presentation by the three sister agencies on program initiatives in mental health services. The group expressed interest in such a presentation.

Ms. King suggested that HFS add adolescent care measures like immunizations such as, Meningococcal, HPV and DTaP vaccines, as an option within health insurance plan measures. Ms. Gordon commended Ms. King on her good ideas and suggested that she summarize them in writing for the Care Coordination Subcommittee.

Ms. Chan asked if the committee could get an update from the department's perspective on the health benefits exchange. If not today, she would like it included in the director's report at the next MAC meeting.

Jan Costello complemented the department for the series of stakeholder meetings regarding the Integrated Care Program. It was very helpful for stakeholders to hear Aetna and IlliniCare representatives to learn how the program was structured, would be rolled out, and how to contact providers. The initial meetings have led to productive follow-up meetings with providers at regional sites.

Andrea Kovach asked if questions about the care coordination recommendations document should be brought up at the next MAC meeting or would the MAC vote on recommendations at the next meeting. Dr. Pont stated that he was not sure there would be a vote. He had envisioned that the MAC would take a few months to look it over and then have a final discussion. The recommendation could become an addendum to the minutes and any MAC member could call it for a vote. So there is more time to discuss recommendations. Gary Fitzgerald asked about the budgetary implications of some of the recommendations. He would like to know if the care coordination fee and stratification is a zero-sum game or is there additional money to be expended along with the specialty portal referral fee and the performance dollars.

VIII. Adjournment

The meeting was adjourned at 11:30 a.m. The next meeting is scheduled for November 18, 2011.

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

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Telephone: (217) 782-1200
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Medical Assistance Budget Management Policies
August 3, 2011

A. HFS paid down outstanding Medical Assistance bills on June 30th to maximize enhanced ARRA federal match.

B. The FY12 Medical Assistance budget enacted by the General Assembly contains $1.4 billion in an unfunded spending gap compared to the Governor's introduced budget.

C. For the period from July-December, with limited resources to pay all outstanding FY11 bills for the State, the Comptroller has notified HFS it will pay bills only up to $100 million GRF (gross) each month for July-August, and $300 million (gross) GRF for each month from September-December. Since July 1, two weeks of payments have been made to all expedited providers ($75 million in gross spending). A total of $125 million (gross) is remaining to August 31.

D. With the Comptroller's spending cap and other unfunded budget pressures, HFS has developed the following budget management plan:

a) For all providers not referenced (in b – e) below, the payment cycle (i.e. voucher release) will be held for the first 120 days;

b) For all hospitals:
   1) Assessment-related payments will be accelerated to make 12 months of assessment-related payments in 6 months;
   2) One month of supplemental payments will be made during the month of August to hospitals with 40% or more revenues coming from Medical Assistance;
   3) In the long term, HFS plans to make all supplemental payments on a monthly basis.
   4) For non-expedited hospitals, the claims-based payment cycle will be held for the first160 days.

c) For expedited hospitals:
   1) Schedule has been developed to make 1 or 2 additional payments in August (in addition to 2 paid in July);
   2) The policy thereafter will be as follows:
      i. Payments will be made weekly for claims aged at least 12 days for hospitals with 40% or more revenues from the Medical Assistance program:

ii. Payments will be made weekly for claims aged at least 60 days for other expedited hospitals qualifying under 89 Ill Adm. Code 140.71(b);
iii. Only hospitals fully qualified under 140.71(b) will be placed in expedited status;
iv. A provider's expedited parameter will not be lowered, unless specifically authorized in writing, by the Director of HFS or the Medical Administrator.

d) For practitioners:
1) Expedited practitioners will receive four more weekly payments prior to August 31st; HFS plans to make weekly payments to these providers as the Comptroller spending cap increases;
2) Non-expedited medical practitioners will receive two additional payments during the month of August.

e) For other expedited providers:
1) Schedule has been developed to make 1, 2 or 4 additional GRF payments in August (in addition to 2 paid in July), targeted to smaller providers that serve the highest percentage of Medicaid clients (i.e. providers who have limited abilities to cost shift to other payers, e.g. community health centers, hospice and medical transportation providers);
2) Nursing homes with 40% or more revenues from the Medical Assistance program will be paid via the Long-Term Care Provider Fund;
3) Expedited pharmacies will be paid weekly via the Drug Rebate Fund;
4) The policy thereafter will be as follows:
i. Payments will be increased by 10 days over their original setting (excluding decreases for end of FY11 claims);
ii. Only providers fully qualified under 140.71(b) will be placed in expedited status;
iii. A provider's expedited parameter will not be lowered unless specifically authorized in writing, by the Director of HFS or the Medical Administrator.

ILLINOIS DEPARTMENT OF Healthcare and Family Services

MEDICAL PROGRAMS REFORMS, EFFICIENCIES AND IMPROVEMENTS
Required by State and Federal Law/Policy

PROGRESS REPORT: SEPTEMBER 15, 2011

	ACTION	COMPLETED	SUBSTANTIAL PROGRESS	PENDING	NOTES
1	Eligibility verification changes re monthly income			X	Paper requirements for clients not approved by federal government; RFP being issued for vendor with income data to perform electronic match
2	Eligibility verification changes re residency			X	Paper requirements for clients not approved by federal government; electronic data match being developed with Secretary of State
3	Annual redetermination of eligibility			X	Effective date 10/1/11; have not received approval from federal government yet
4	Cap on eligibility for All Kids children to 300% FPL; sunset extended to 7/1/16	X			Effective 7/1/11
5	Cap on eligibility for FamilyCare adults to 133% FPL			X	Not effective until 1/1/14
6	Cap on eligibility for seniors/disabled in Illinois Cares Rx to 200% FPL; increases in co-pays	X			Effective 9/1/11
7	Medicaid eligibility for justice-involved populations			X	Policy maintaining eligibility while in jail or prison under development; service delivery planning underway by consortium of organizations, for justice-involved populations who will become Medicaid-eligible on 1/1/14
8	Hospitals: rate adjustments for outliers, critical access hospitals, long-term care hospitals	X			

	ACTION	COMPLETED	SUBSTANTIAL PROGRESS	PENDING	NOTES
9	Hospitals: comprehensive rate reform			X	New Technical Advisory Group reviewing policy issues for inclusion in legislation in spring, 2012
10	Hospitals: increased co-pays for non-emergency visits			X	State plan amendment will be submitted to federal CMS
11	Nursing homes: comprehensive rate reform incorporating new assessments			X	New Technical Advisory Group reviewing policy issues for inclusion in legislation in spring, 2012; state plan amendment pending with federal CMS; rule pending before JCAR
12	Nursing homes: new certificate of psychosocial rehabilitation for any nursing facility serving persons with serious mental illness			X	Rule being drafted
13	Nursing homes: new transfer of asset rules under federal Deficit Reduction Act		X		Rule pending before JCAR
14	Non-emergency transportation: increased restrictions for nursing homes			X	
15	Non-emergency ambulance transportation: new appeals process		X		PA 97-584 signed August 2011; rule being drafted for submission to JCAR
16	Pharmaceuticals: increased utilization management of certain psychotropic drugs and narcotics	X			New preferred drug list implemented in May
17	Pharmaceuticals: increased co-pays			X	State plan amendment to be submitted to federal CMS
18	Pharmaceuticals: 90-day prescriptions for certain maintenance drugs			X	Requires programming change in IT systems; programming change request drafted
19	Pharmaceuticals: restrictions on certain over-the-counter drugs	X			Coverage ended in July

	ACTION	COMPLETED	SUBSTANTIAL PROGRESS	PENDING	NOTES
20	Pharmaceuticals: adjusted reimbursement rate for ingredient costs, per federal lawsuit settlement			X	Rule pending before JCAR; state plan amendment to be submitted to federal CMS
21	Pharmaceuticals: bulk purchasing for specialty drugs			X	RFP to be issued; waiver request to be submitted to federal CMS
22	Care coordination: Integrated Care Program launched, providing mandatory managed care for 40,000 seniors and persons with disabilities in suburbs/collar counties	X			
23	Care coordination: Innovation Project being developed to solicit new models of care coordination		X		White Paper published with 76 responses received; Medicaid Advisory Committee Care Coordination Subcommittee formed; solicitation expected to be launched 1/1/12
24	Care coordination: new models of care for children in Medically Fragile/Technologically Dependent Waiver and other children with complex medical needs			X	Task Force on Children With Complex Medical Needs organized, reviewing policy issues
25	Care coordination: Medicaid data available to potential vendors/providers to support care coordination initiatives		X		Medicaid Data Analytics and Reporting Platform Request for Information, Issued by consortium of foundations
26	Care coordination/long-term care rebalancing			X	Facility closures announced; Williams/Ligas lawsuit settlements being implemented; Colbert consent decree preliminarily approved, with fairness hearing set in December; unified budget analysis being coordinated by GOMB; new demonstration projects and waiver opportunities from federal government under consideration
27	Care coordination: better care for women at risk of poor pregnancy outcomes		X		High Risk Maternity and Interconception Care Program in development

	ACTION	COMPLETED	SUBSTANTIAL PROGRESS	PENDING	NOTES
28	Care coordination: linkage of services for children with developmental delays		X		Electronic referral system in development to link HFS' primary care providers and DHS' Early Intervention Child and Family Connections
29	Care coordination: primary health care provider access to mental health records of Medicaid clients	X			PA 97-515 signed August 2011; outreach campaign to be developed
30	Increased access to quality breast cancer screenings and navigation services to reduce cancer		X		Breast Cancer Quality Screening and Treatment Initiative, guided by expert Quality Board, planning changes by 1/1/12
31	Increased access to dental services	X			25 new or expansion dental clinics funded in local health departments and FQHCs; HFS/IDPH interagency agreement provided in the School-Based Dental Program
32	Increased access to quality child healthcare			X	With federal demonstration grant, working with large stakeholder group to adopt core set of child health quality measures and improved birth outcomes
33	Support for women to plan their pregnancies to reduce the risk of poor birth outcomes		X		Renewal of federal waiver requested to permit HFS to continue Illinois Healthy Women program until Affordable Care Act is implemented in 2014
34	Civil and administrative remedies for recipients who abuse the system		X		Statutory report due 7/2012; rules have been drafted for submission to JCAR
35	Expanded Recipient Restriction Program for persons who abuse system		X		Rules have been drafted for submission to JCAR
36	Cross-Agency Medicaid Commission review of opportunities to maximize federal match		X		Statutory report due 12/31/11
37	Payment recapture audits			X	RFP to be issued, but was delayed until federal CMS published rule governing this program (Final Rule just published Sept. 14)
38	Enhanced third-party liability payments			X	RFP to be issued, following analysis of current third-party liability claiming

	ACTION	COMPLETED	SUBSTANTIAL PROGRESS	PENDING	NOTES
39	Mental health services billing and payments shifted from DHS to HFS		X		Services being billed directly to HFS; payment system in final stage of testing
40	Medicaid Transparency Program providing online data of Medicaid enrollment and claims	X			New consumer-friendly website lists enrollment data sorted by counties, districts, zip codes; other data to be added
41	Reduced prompt pay interest for providers from 24% per annum after 60 days to 12% per annum after 90 days	X			
42	DD Long-Term Care assessment revenue increase to federal maximum (impacts DHS budget)			X	DD LTC assessment tax rate to increase from 5.5% to 6% of the prior State Fiscal Year's adjusted gross DD LTC revenue
43	Federal matching dollars on All Kids 200%-300% of poverty, including retroactive claiming		X		State plan amendment filed with federal CMS
44	New durable Medical Card replacing monthly paper cards		X		RFP pending
45	Continuous updating of addresses of Medicaid clients from U.S. Post Office			X	Plan in development with DHS
46	Streamlined Eligibility/Verification/ Enrollment process for Medicaid, TANF, SNAP and WIC			X	Second federal planning grant received; RFP to be issued in mid-2012
47	Comprehensive Technology Plan for health and human services agencies	X			Plan filed on 7/1/11; implementation underway
48	Illinois Health Benefits Exchange			X	Second federal planning grant received; Legislative Study Committee reviewing policy issues
49	Electronic Health Record (EHR) incentives for "meaningful use" of EHRs for Medicaid clients	X			Launched 9/6/11; $150 million in federal dollars expected to be awarded to Illinois practitioners and hospitals in FY 12

Draft Draft Draft

Care Coordination Subcommittee of the Medicaid Advisory Committee (MAC)

Recommendations for modification of the PCCM to comply with the Illinois Medicaid Reform Law

Introduction

The Illinois Health Reform Law calls for 50% of Medicaid clients to be enrolled in a care coordination entity by 2015. Though the Law specifically prohibits the current Primary Care Case Management program (PCCM) from participation in this 50% requirement, it also allows for the possibility that a modified PCCM can qualify as a care coordination entity under the scope of the Law. To this end, in March 2011 the Medicaid Advisory Committee (MAC) established a subcommittee to explore ways that the PCCM might be modified so it remains a viable option as Medicaid reform in Illinois proceeds.

By any reasonable standard, the PCCM has performed admirably, both in terms of clinical outcomes as well as cost savings. MAC also notes the PCCM is widely accepted by providers, 85% of whom accept PCCM patients into their practices. Especially given the expected influx of new patients as a result of federal health care reform efforts, preserving the PCCM in all areas of the state is a laudable goal as acceptance by providers is a crucial ingredient in the overall success of the Medicaid program.

MAC recommends the following changes be considered by the Department to modify the current PCCM program. MAC further recommends that, if these changes are implemented, the Department certify the PCCM as a care coordination entity and allow PCCM clients to qualify toward the 50% requirement stated in the Law:

1. Stratification of the monthly care coordination fee (CCF)

Currently, the PCCM pays providers a monthly CCF ranging from $2 to $4 per member per month (PMPM). This fee is paid irrespective of services provided to the Medicaid client. MAC recommends this fee be stratified based on various clinical criteria. Medically straightforward patients should receive a baseline CCF, while medically complex patients should receive an enhanced CCF indicative of the amount of work necessary to coordinate their care. MAC also recommends the Department investigate other options to stratify the CCF based on practices' degree of adherence to the medical home concept.

MAC believes this stratification of the CCF will have several positive effects. First, it will motivate practices to contact patients who have not received necessary preventative care. Second, it will promote the medical home model by reimbursing providers for care that is not quantifiable under current payment methodologies: phone calls, interpretation of lab results, consultation with specialists, etc. Finally, an enhanced CCF for medically complex patients will incentivize providers to accept these patients into their practices, giving them a medical home to keep them healthy and reduce unnecessary ER and hospital utilization.

MAC also notes that the CCF represents significant provider reimbursement. According to the most recent HFS annual report, the CCF represents approximately 10-15% of primary care reimbursement. A provider with a typical panel size of 300 patients receives over $7,000 annually in CCF payments.

2. Improve Communication Between PCPs and Specialty Physicians

Via the MEDI portal, the PCCM can facilitate communication between PCPs and specialists. However, MAC notes that this function is currently underutilized. Recognizing that good communication between the medical home and specialist physicians remains both an important and vexing problem, MAC recommends the PCCM encourage utilization of this portal. Specialists could review symptoms prior to the patient's arrival, instruct the PCP to order tests for review at the visit, even redirect the patient to other resources should a consult be unnecessary.

MAC recommends specialists be reimbursed for utilizing the MEDI portal, reflecting the time involved in reviewing patient data and making initial recommendations for care. MAC further recommends the state consider Cook County's IRIS program as an example of this type of functionality.

3. Development of Regional At-Risk Pools

The Law states that the coordinated care entities that HFS contracts with must accept some risk, though MAC notes the amount of risk necessary is not specified in the Law. As noted above, modifying the CCF would place significant provider reimbursement at risk, and in responses to the HFS coordinated care discussion paper several organizations expressed concern that too much down-side risk could restrict provider participation in the Medicaid program.

MAC therefore recommends HFS establish regional risk pools to distribute additional care coordination funds based on performance measures (i.e., ER utilization, hospital readmission, etc.). HFS could designate various organizations to adjudicate disbursement of these funds, such as county health departments. The cost savings these regional risk pools generate could then be shared with the region's providers.

4. Enhance utilization of current PCCM capabilities to optimize care provided across multiple settings

MAC notes that there are opportunities within the current PCCM to enhance the coordination of care across multiple settings. In addition to the specialist communication portal (above), MAC recommends HFS develop strategies to enhance utilization of: ER coordination utilizing the "Who's My PCP?" function; ICARE for immunization tracking; and the IHC appointment reminder function.

Biography for Susan Hayes Gordon

Susan Hayes Gordon is Chief Government and Community Relations Officer at Children's Memorial Hospital in Chicago and has served in that capacity for 24 years. Ms. Gordon's department is responsible for identifying and implementing initiatives that will serve to strengthen the community and governmental partnerships that are key to the hospital's future and its goals. She was central to developing and implementing a plan for support and approval of Ann & Robert H. Lurie Children's Hospital of Chicago. With the assistance of the hospital's key clinical, management and volunteer teams, she directed the hospital's interface with the local, state and federal leaders and organizations that were intimately involved in all aspects of the planning of the new hospital. In addition, Ms. Gordon is the hospital's point person in connection with healthcare reform.

Under Ms. Gordon's leadership, the medical center seeks to foster awareness and participation among its constituencies to enhance the health and well-being of all children and, with that in mind, to secure appropriate Medicaid and graduate medical education reimbursement for the significant number of children Children's Memorial serves who rely on Medicaid.

A Leadership Greater Chicago Fellow, Ms. Gordon has served on numerous policy committees with the National Association of Children's Hospitals, the Illinois Hospital Association, and the Ounce of Prevention Fund. She has served since 2000 on the state of Illinois' Medicaid Advisory Committee and has served as a board member of the Illinois Council Against Handgun Violence.

Biography for Kathy Chan

Kathy Chan is the Associate Director and Director of Policy and Advocacy for the Illinois Maternal and Child Health Coalition, a nonprofit that uses policy, advocacy, and community empowerment to improve the lives of women, children, and their families. She leads advocacy efforts for IMCHC's four projects and serves as the primary contact with legislators and other policymakers.

Since the passage of the Affordable Care Act, Kathy has been providing education about the tremendous impact this historic legislation will have on community health, as well as mobilizing stakeholders to support policies that ensure efficient and effective implementation.

From 2002-2006, Kathy worked at IMCHC on Covering Kids and Families where she built statewide and local coalitions and created and implemented strategies to help families more easily access public health insurance programs. Her efforts helped Illinois gain recognition as a national leader in enrollment.

Kathy also worked in state government with the Illinois Department of Healthcare and Family Services, where she assisted with strategic enrollment efforts and the implementation of All Kids. She is an appointed member of the Illinois Medicaid Advisory Council, the Board Chair of IFLOSS, a statewide organization working to improve the oral health status of residents, and is an active volunteer with the Young Nonprofit Professionals Network of Chicago.

Kathy graduated with a BA in English from Northwestern University and began her career as an organizer with Green Corps, a field school for environmental organizing.

Medicaid Advisory Committee

2012 Meeting Dates

January 20, 2012

March 16, 2012

May 18, 2012

July 20, 2012

September 21, 2012

November 16, 2012