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
TTY: (800) 526-5812

Memorandum

DATE: January 13, 2012

TO: Members of the Medicaid Advisory Committee

FROM: Julie Hamos
Director

RE: Medicaid Advisory Committee (MAC) Meeting

==========

The next meeting of the Medicaid Advisory Committee is scheduled for Friday, January 20, 2012. 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, a handout, and the draft minutes from the November 18, 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

January 20, 2012
10 a.m. - 12 p.m.

AGENDA

I. Call to Order

II. Introductions

III. Approval of November 18, 2011 Meeting Minutes

IV. Director's Report

V. Update on Dual Medicare/Medicaid Care Integration Financial Model Project

VI. Update on Innovations Project
- Performance and Quality Measures
- Status of Solicitation
- Status of Data Development

VII. Subcommittee Reports
- Care Coordination Subcommittee Report
- Public Education Subcommittee Report
- Long Term Care Subcommittee Report

VIII. MAC Priorities for 2012 — Open Discussion of Member's Ideas for Priorities

IX. Review of Subcommittees

X. Open to Committee

XI. Adjournment

From: J King [mailto:judyking15@gmail.com]
Sent: Wednesday, January 11, 2012 2:25 PM
To: Hayes Gordon, Susan
Cc: Margaret Kirkegaard
Subject: MAC Meeting

To: Ms. Hayes Gordon, MAC Chairperson

I would like to propose three action items (in draft below) for the January MAC meeting agenda.

Health Disparities

(1)The Medicaid Advisory Committee should recommend that HFS implement a policy /practice of identifying and addressing racial/ethnic, primary language, and geographic, disparities in medical program enrollment, access, utilization, and outcomes for HFS beneficiaries. In addition, HFS should publicly report (such as in its annual, PCCM, medically fragile, external quality review, Integrated Care Program, annual budget, and care coordination reports) on its efforts to correct identified disparities in health care program enrollment, access, utilization, and quality.

Agency Transparency

(2) The MAC should recommend greater transparency in HFS' public reporting. HFS should make available on the website *at least* the following standard reports [in addition to what's already posted]: Children's Health Insurance Program Annual Report, EPSDT annual report, annual PCCM report, Medicaid State Plan, biannual [fall, spring] PCCM statewide provider profile reports. HFS should present some of its annual reports to the MAC for comment.

(3) It is recommended that the HFS include in its annual correspondence to beneficiaries notice of the existence of ongoing opportunities for public involvement in decision-making about HFS programs (i.e., via the MAC, Public Education, and other committees).

Other issues for the MAC agenda:

Mental Health Services

At the September meeting there was consensus that HFS should review, with the MAC, Medicaid funded services/responsibilities for individuals needing mental health care (i.e., programs, access, utilization, primary care, EPSDT, multiple consent decrees). Does HFS plan to address mental health services at this month's MAC meeting?

Adolescent Health Care

HFS has been asked to report on adolescent health care services. HFS did not include any reporting on adolescent health measures in HFS' 2010 Children's Health Insurance Program Annual Report. Does HFS plan to address adolescent health services at this month's MAC meeting?

There are state (DMH) and local (CDPH, CPS) grant programs targeted towards adolescents and there should be some review of how all of these programs are working together to severe our youth.

It would be helpful if HFS could at least review immunization levels, disparities in vaccine access and uptake (if any), and how HFS' MCO and PCCM programs and VFC are addressing access to HPV, Tdap, meningococcal vaccine, influenza, in addition to catch up immunizations (MMR, Hep B, IPV, varicella, etc) and vaccines for individuals with additional risks (Hep A, pneumococcal, etc.).

Access to Specialty Care

HFS should report on how it is monitoring access to pediatric specialty care and whether the special arrangement with Cook County Health Services is working. HFS should report on access to adult specialty care, too.

Thank you for your consideration.

Judy King

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
November 18, 2011

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

Members Present
Eli Pick, Chairman
John Shlofrock, Barton Mgt.
Judy King
Mary Driscoll, DPH
Jan Costello, IL Home Care & Hospice Council
Renee Poole, IAFP
Sahar Alrayyes for Melissa Vargas, AAPD
Head Start
Karen Moredock, DCFS
Edward Pont, ICAAP
Margaret Stapleton for Andrea Kovach, Shriver Center

Members Absent
Susan Hayes Gordon, Children's Memorial
Kathy Chan, IMCHC
Alice Foss, Illinois Rural Health Assn.
Glendean Sisk, DHS
Linda Diamond-Shapiro, ACHN
Sue Vega, Alivio Medical Center

HFS Staff
Julie Hamos
Theresa Eagleson
James Parker
Jacqui Ellinger
Robyn Nardone
Andrea Bennett
Sally Becherer
Amy Wallace
Ann Lattig
James Monk

Interested Parties
John Bullard, Amgen
Mary Capetillo, Lilly
Kelly Carter, IPHCA
Christine Cazeau, IHC
Robert Currie, Aetna Better Health
Diane Fager, CPS
Andrew Fairgrieve, HMA
Gary Fitzgerald, Harmony
Eric Foster, IADDA
Elizabeth Fu, Heartland Alliance
Jen Hammer, Attorney
Barbara Hay, FHN
Marvin Hazelwood, Consultant
George Hovanec, CMH
Teresa Hursey, Aetna

Interested Parties
Paul Jagunich, United Healthcare
Margaret Kirkegaard, IHC
Keith Kudla, FHN
Erin Laytham, IARF Janine Lewis, IMCHC
Debra Mathews, DSCC
Joy Mahurin, Comprehensive Bleeding Disorders
Mona Martin, Phrma
Susan Melczer, MCHC
Diane Montañez, Alivio Medical Center
Mary Reis, DCFS
Ben Schoen, Meridian
Suzanne Stewart, Abbott Diabetes Care
Chester Stroyny, APS Healthcare
Jessica Williams, CPS - CFBU

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
November 18, 2011

I. Call to Order

Theresa Eagleson, HFS' Administrator for the Division of Medical Programs, called the meeting to order at 10:05 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Review of September 16, 2011 Meeting the Minutes

Director Hamos asked if there were any corrections to the minutes. None noted; the minutes were approved.

IV. Election of Officer Candidates

Ms. Eagleson introduced the members of the nominating committee present, Jan Costello and John Shlofrock. Mr. Shlofrock reviewed the process of working with HFS to name candidates. The committee had agreed that Susan Hayes Gordon of Children's Memorial Hospital be nominated as Chairperson and Kathy Chan of the Illinois Maternal and Child Health Coalition (ICMHC) be nominated as Vice-Chairperson.

Ms. Eagleson stated that biographical information on both candidates had been shared ahead of time with the MAC. She then opened the floor for discussion on the nominees.

Ms. King indicated that she had a comment about the representation of IMCHC. While both nominees are wonderful candidates, it needs to be noted that IMCHC had received money from HFS, DHS, IAFP and ICAAP. As a point of transparency, it is an issue of independence.

Director Hamos responded that in her 18 months with HFS she has needed to find persons with knowledge of health policy and has rarely found anyone who has that knowledge who doesn't have some affiliation or doesn't have a vested interest in the healthcare system. Everyone who cares about healthcare policy is sitting on some board or is with a provider group. Their participation doesn't mean that they can't be objective or be good partners or advocates.

Chairman Pick called for nominations from the floor. There were none. With a quorum, the vote was called. The motion to approve the recommendations of the nominating committee carried 7 to 1. The nominees would be notified and be installed at the next meeting.

V. 2012 Meeting Dates

The schedule of the 2012 meeting dates was distributed as part of the meeting packet showing the dates as January 20th, March 16th, May 18th, July 20th, September 21st and November 16th. The recommended meeting dates were voted on and accepted with no one opposed and no abstentions.

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

Shannon Stokes from the HFS office of general counsel stated that MAC members should have received the ethics training packet. The members are asked to review the training and complete the acknowledgement form and return it to the department by December 16, 2011. The form may be faxed to Jeff Pentzien, with the original sent by mail. Ms. Eagleson added that HFS had the sent packet to members in October and would send it out again.

VII. Director's Report

Innovations Project

Director Hamos opened by stating that HFS has launched the Innovations Project which is the first phase of our care coordination for the Illinois Medicaid program. It appears there is a lot of community interest. It will

involve community partners getting organized at a grassroots level to figure out how they can best serve complex adults and a little later their children. HFS understands that this is a big challenge and yet we hear that people understand the importance of forming these partnerships. HFS has to be flexible and incentivize partners to be innovative in coming up with program design and funding. We need to break down the silos of state government. So, to the extent you serve complex clients through different agencies, we will work hard to bring that together. HFS is committed to providing claims data about the full extent of our clients' services and associated costs. We are creating a data analytics unit to aggregate data in a way that makes sense to our provider community. We have good support from the foundation community in helping us with this endeavor. This will impose a new discipline on both the department and you to look at the full extent of client costs. HFS is expecting these projects to be at least cost neutral. We hope there will be savings; and to share the savings with providers. HFS feels that the underpinnings of the Affordable Care Act (ACA) is serving patients with complex health conditions and doing it in an innovative way. The ACA is fostering a period of innovation in Medicaid, Medicare and the private sector. Sometime in January, HFS will issue its first Innovations Project solicitation.

Dr. Kirkegaard asked if the data will be raw data or if there will be some uniform analysis; specifically will there be a uniform adjustment for risk stratification because the patient populations for the care coordination fees are relatively small. One patient with an unexpected event could completely eliminate any cost savings. For example, if you have 500 patients with mental illness and one is hit by a bus, thus spending a year in the hospital, there would be a huge amount of expenses that are unrelated to the conditions that you agreed to manage. So, will there be uniform risk stratification for the assessment of the CCEs and the cost to manage them?

Ms Eagleson stated that HFS is trying to figure out how to aggregate data and group people in meaningful ways. The department is working on a way to re-stratify. That is one part of the work for the data analytics unit the Director mentioned. Mary Driscoll indicated that IDPH re-stratifies data and would be happy to assist HFS with this effort.

Keith Kudla stated that beyond risk re-stratification there is the need to differentiate between insurance risk and performance risk. If you have an adverse case and 500 members, there isn't enough volume to spread that risk. HFS might want to consider something that was in the Health Exchange regulations, whether a CCE or MCCN, is to provide reinsurance at a certain attachment point that takes the insurance risk off the back of the providers so they can focus on the things they can control and influence, or what is called the performance risk. ACA will offer reinsurance for the very scenario Dr. Kirkegaard described.

Director Hamos replied that we need to remember what HFS has set forth is a concept to allow the providers to come together as Care Coordination Entities (CCEs) and not take full risk for the medical services. What CCEs are at risk for is the care coordination. Dr. Kirkegaard noted that the department had said if a CCE doesn't have cost neutrality, the CCE wouldn't continue. They may not be able to stay cost neutral if there is a cost that is out of control. Mr. Kudla added that even for the providers at FHN, where they do not transfer risk, FHN still reinsures their pool so they are not adversely affected by insurance risk versus performance risk.

Ms. Eagleson stated these are all really good points and that the department will be discussing ways to handle this. HFS is not requiring a full capitation, full risk situation under Phase I of the Innovations Project. The department is looking at the cost of the entire population that a group proposes to serve over a three year period of time and considering ways to limit those extreme outliers.

Legislative Issues

Director Hamos advised the group that the budget this year is going to be worse than ever. It is shocking that this has happened so quickly, because as of June 30th, we still had the enhanced match and were able to pay off many of the outstanding bills. At the end of the year, the department will have $2.5 billion in outstanding bills. HFS was underfunded and the legislature balanced the state budget partly by underfunding the Medicaid program. In theory, HFS could respond to this by delaying the payment cycle. We are just approaching a 120

day payment cycle where providers have not been paid for the new fiscal year. Everyone is beginning to feel that squeeze and we anticipate there will be a lot of pressure on the Medicaid program to once again look at eligibility, optional services and utilization. Just when we thought everything had been put on the table last year, we'll be asked to look for more savings.

Ms. King stated that there needs to be data available to the public in general. There are different interests in terms of what people may want to know about whose being served and how well without concern for the providers' reputations. The department's presentations to the legislature haven't included data on who is being served and the outcomes. If people aren't getting adequate care now that should be presented so people can vote responsibly on the various budget issues. Another concern is about programs being cost neutral and shared savings. We've heard about savings in the PCCM and DM programs but it has never been made clear to the public how HFS derives those savings. When HFS looks at these new programs it is not clear as to what the basis is for determining that a program saves money while maintaining or improving the level of care.

Director Hamos replied that we've had conversations before about data and asked the committee to hone in on exactly what HFS can do. Our imagination runs wild on the kind of data we could produce on 2.7 million people. HFS doesn't have the capacity to respond to a lot of data requests. We're short staffed at our management levels, but, we can do some things and we do want to be responsive. For example, HFS can give data on children and hone in on the children with the most complex needs. HFS has about 1.8 million children in All Kids. Of those, 1.5% or 2,723 use 20 % of the total pediatric costs totaling almost $600 million. We can tell you how many are getting wellness visits and immunizations, but what the legislature really cares about is how HFS can save money. We believe in care coordination because given the kind of fragmented unmanaged care we have right now, we know there are services we can provide at less cost by coordinating services.

Director Hamos moved on to explaining that a key structure in implementing the Affordable Care Act (ACA) is the Illinois Health Benefits Exchange, for which we are working closely with the Illinois Department of Insurance. There are two components. The first component is to be able to access or apply for healthcare in a streamlined efficient way. Illinois is developing the Integrated Eligibility System (IES), formerly called EVE, which will allow people applying or qualifying for Medicaid or applying for private insurance with access to tax subsidies, to use a new efficient integrated system. We have two years to get that done. With a short time frame and a 90% federal match we will make this happen. The second component is called the Electronic Market Place, where the insurance industry will offer products to individuals and small businesses. To move these along, we needed action by the legislature before the end of the veto session. It didn't happen, so right now there aren't votes to have Illinois run its own Health Benefits Exchange. There is a part of this that says the federal government will run it and if CMS runs the exchange, they will likely set some of the eligibility rules for Medicaid. Jacqui Ellinger, Deputy Administrator, Policy Coordination, noted that coordinating with the federal CMS on an exchange they run would present bigger challenges than coordinating with another state entity.

Director Hamos explained that the administration, the advocates and the insurance industry all want the exchange, but we can't get the votes. HFS has been working with the insurance industry and we thought they could probably find a few votes. This is a problem and we don't know where that is going. On the eligibility side we are moving ahead. The two components are linked, but not conditioned on each other.

Chairman Pick commented that the Center for Medicare and Medicaid Innovations has been soliciting letters of intent for condition specific risk pools and will only make data available to grant applicants. The applicants are responsible for converting that raw data and billing data to the useful information they need in order to submit a final proposal. He would caution the department from trying to go too far producing data in a variety of forms, although it is the billing data and experiential data that care coordinators require to extract information they need to put together some type of a strategy and cost model for managing specific populations.

Mary Driscoll stated that IDPH has a mandate to publicize data to consumers and do it through a hospital report card and public health survey map. This is available on the IDPH website. IDPH is available to help HFS with publicizing data.

Margaret Stapleton asked what health conditions are represented for children accounting for 20% of pediatric cost. The Director replied that the top three are pre-term babies, technologically dependent children who need ventilator care in the home, and hemophiliac children.

Ms. Stapleton was interested in knowing as there are issues with getting private insurance for newborns in Illinois and the situation might get worse. Her understanding is only one insurer in Illinois will write a stand-alone policy for children under age one. Ms. Ellinger responded that, in general, insurers are not writing children-only policies with the exception of Blue Cross. What we have seen over time with the technologically dependent children is a redefinition of in-home care as custodial care and therefore not covered under the medical necessity clauses of the insurance contracts. Director Hamos added that some children have private health insurance, but not for some of these services and therefore turn to Medicaid for coverage of those services.

Ms. King stated that CMS has a website, Data-Cube, with Medicaid statistical information and some reports like total claims and unique beneficiaries. The data is aggregated based on eligibility, age group and race-ethnicity for various programs. She is not aware of this data being used by anybody right now and it could be used. The website has information that is relevant to serving medical assistance beneficiaries. For example, if you sort by race under capitated care, the majority of enrollees, 61%, are black and another large percent are Latino. There are very few whites in capitated care. That is important if you look at the outcomes of those programs and the external quality review reports. She is concerned about the inequities she sees under the capitated care programs. She will do as Susan Gordon-Hayes had suggested and put some examples in an email to her. Ms. King noted that there is data that can be useful if we are concerned about social equity and justice.

VIII. Dual Medicare/Medicaid Care Integration Financial Model Project

James Parker, Deputy Administrator, Operations, stated that the federal government has offered states the opportunity to test two methods of integrated care for dual-eligibles (Medicaid/Medicare). One method is a dual capitation full risk model. HFS would put dual-eligibles into HMOs which would be responsible for services covered under both Medicare and Medicaid. The HMO would receive capitated payments from both the federal and state governments. The other model offered is called managed Fee-for-Service (FFS). There isn't a lot of detail on what that means, but it sounds similar to HFS' Innovations Project. If the state puts together a fee-for-service system that manages the care of dual eligibles and the system produces savings on the Medicare side, the federal government will share some of the savings with the state. It is an opportunity for HFS to get some extra federal dollars based on Medicare savings.

Illinois filed a letter of intent to participate under the project using both models and received approval from the feds. The department has begun discussions with the federal government. For the managed FFS model, the department is trying to confirm that it can be folded into our Innovations Project. Both the timeline and process under the capitated model fits in with HFS issuing a RFP in the spring for HMOs to take on the dual-eligible population. This would be a joint RFP with the federal government. HFS has a desire, and requirement, to get stakeholder input, so, we bring it to the group today to lay it out for you. There is a one page handout, *CMS Financial Models to Support Efforts to Integrate Care for Medicare-Medicaid Enrollees* (Attachment 1). The department welcomes you to review it, now or later, and provide input on how we should go forward with either or both models.

Chairman Pick asked how this lines up with CMS initiatives for their acute or post-acute models for managing those episodes as opposed to managing those populations. Mr. Parker responded that they don't mesh together necessarily. This model is a full integration of all services. CMS has made it clear that they are not interested

in any service carve-outs and want everything in these models, including waiver services on the Medicaid side. It is the full range of services for the defined population.

Director Hamos added that Illinois has about 400,000 people under the SPD program and about 250,000 are dual-eligible clients. This is an important population that we have not focused on before. The federal government is very interested in a different kind of care coordination for this group. They are incentivizing care coordination and saying that the vendor has to be ready to sign up people by the end of 2012. HFS would issue a RFP with federal guidance, sometime in the spring and make awards by the year's end.

Chester Stroyny asked if HFS is planning, for the January solicitation for the Innovations Project, to be ready to bring in some of those duals for the FFS model using the care coordination approach. Director Hamos replied that we had identified in our October presentation that duals are one component in our complex population category.

Keith Kudla asked if the entity has to be an HMO for the capitated model for duals. Mr. Parker advised that the federal government's preliminary answer is that they are open to non-insurance models. Non HMOs, MCCNs, and even other entities, that they feel can take the risk.

IX. Subcommittee Reports

Care Coordination Subcommittee Report

Dr. Pont reported that the subcommittee met on November 15th and had a large attendance, good participation, and robust discussion about what performance quality measures should be included; not just in a baseline for all CCEs, but other measures an entity would want in taking care of a specific population. There was a good discussion on the adult side during which some base level care coordination measures to be applied across the board were recommended. Discussion also occurred on the special populations. On the pediatric side, the HEDIS measurements used in the PCCM model would be accepted as the base, with the CCEs adding measures they believe critical to the population being served. The importance of this information being public as the department moves to a more consumer driven model of healthcare was mentioned in order for people to make an informed choice about what CCE may be right for them. There was also a discussion that in order to adequately track and report on the performance quality measures a robust Electronic Health Record (EHR) is critical. The subcommittee's next meeting was tentatively scheduled for Tuesday morning, January 10th and the planned topic is consumer issues and how we want the whole care coordination system to look to consumers. For example what they would find of value and how the information would be organized so they can access it.

Ms. Stapleton asked Dr. Pont what he thought the consumer issues are. He shared that as a pediatrician and parent, he should be able to tell which CCE works with health conditions affecting a child. For example, being able to identify which clinics treat children with asthma or with fluid in the ear. The key issue is that the information is out there and easily accessible. This could be on the department's website. We are interested in what measures people want to see and what measures is it possible to put out there.

Mary Driscoll suggested that we want to say that an excellent primary care entity is one that covers all the primary care basics, following all the EPSDT guidelines. Ask if they have the appropriate referral network. For her the first part is to see a well child to prevent them from becoming ill.

Director Hamos added that a simple thing is to give the office hours and show if there are extended hours or 24/7 coverage. There was agreement that this access information is a real consumer issue. Dr Pont shared his example of a mother calling about a child with a fever could be redirected from the emergency room to a physician's office in a way that would help the child and save the ER expense for the department.

Dr. Pont recognized the leadership of Chairman Pick for his good mentoring and service to him. He referred to the subcommittee's primary charge of suggesting ways to modify the PCCM program such that it could participate in the 50% requirement in the Medicaid Reform law. From the last meeting's minutes it seemed

that HFS staff wanted to get back to the subcommittee at this meeting. He was interested if the department had any comments at this time regarding the subcommittee's charge.

Director Hamos commented that thinking about this subcommittee and coordinated care and the very broad and ambitious goal of 50% that had started last spring, and later on as part of the developmental process, and what that meant, the department created the Innovations Project under which the focus is on partnerships. It is not about individual doctor's offices, but about partnerships. HFS said we wanted to look at more than just getting fully capitated managed care entities to cover recipients, but to see what we could create at a grass roots level by incentivizing providers to work together. At the minimum there needs to be three components to this, primary care physician, hospital and behavioral health. So for HFS, even with recommended modifications from the subcommittee, the PCCM would not be considered a care coordination entity without the partners.

Dr. Pont asked for further clarification, as the PCCM does partner with other entities like specialist, hospitals and the Doc Assist hotline. Director Hamos stated that HFS is looking for real structural relationships that include partners that are willing to sign letters of intent to share their clients with each other in order to better organize serving the needs of their clients. A physician's office under the PCCM Program, by itself, doesn't really reach the level of what we want to accomplish under the Innovations Project.

Dr. Pont indicated that as a physician's office participating under the PCCM Programs, he does have a care coordination employee that visits his practice to make sure that everything is going smoothly, to coordinate referrals and to provide him with support. Dr. Pont indicated that he could go back to the subcommittee and say that no additional work is needed from them on this issue, but it would be helpful to be able to tell them what is lacking and what the department would like to see added.

Diane Montañez stated that when this process began a couple of months ago, she also loved the PCCM model with Illinois Health Connect. She likes the data and the reimbursement. But, the more she has read about the concepts of MCOs, CCEs and coordinated care, she realizes that as good as the PCCM model is, and that certain parts have to remain, there is a lot more with communication and networking that needs to happen. For this model to work, her organization will have to partner with other FQHCs and hospitals. The difference between the PCCM model and the future model is one that connects her organization with other partners whereas now her organization does these connections itself.

Ms. Driscoll observed that with the networks that are currently forming, accountability is a big issue and within the networks providers will be held accountable. The best ones forming now and working have the ability to monitor their own quality. To be able to create organizations that can pass through the levels of care and be accountable for them really has the potential to add value to what is being done.

Chairman Pick added that the dynamic that he is observing is consolidation. PCCM offered an opportunity for collaboration and now the market is demanding integration. This is not just on a care coordination level but on an economic level, so that different independent entities, as opposed to having collaboration now, we have to have a shared economic risk for delivering an outcome. PCCM can't do that. It can collaborate and integrate care at a higher level than a disjointed system of independent practitioners working for a common goal. Once the economic piece becomes integrated into the performance expectation, it changes the rules of the game.

Dr Pont advised that the subcommittee had discussed a method to put a significant amount of risk into the PCCM. There is at least anecdotal evidence that people do respond to those types of risk. This is what we are expecting the model to evolve to. There is nothing inherent in the PCCM model that says there shouldn't be risk. There is data available showing that North Carolina has a wonderful program that has saved money, even as their patient acuity has gone up. The question here is are we going to take a model that has saved money, that is widely accepted by providers and patients, that has provided superior quality and say ,at least where I practice, you're done. I know it will still be around, but your own care coordination query document says and I quote directly that "materially more patients than just 50% will have to be enrolled in Cook and the collars in order to meet the total 50% care coordination requirement." Dr. Pont indicated that he has great reservations

about turning the battleship again, as we did just a few years ago, and taking out the one piece that everyone agrees is saving money and providing quality care. If he were a CCE, or thinking about becoming a CCE, and saw that an entity like the PCCM with a state-wide network and a computer network capable of linking specialists similar to IRIS at Cook County, remind patients of appointments, provide doctors with feedback from psychiatrists with just a call, did not provide the level of care coordination needed, he would be reluctant to throw his CCE hat into the ring. It is not like you are establishing two different standards. There is no reason to establish one standard for the PCCM and another for the care coordination universe. By saying that the PCCM is rejected and doesn't pass care coordination muster, is a concern not just for my practice, but for the whole care coordination effort.

Mr. Parker advised that HFS is not talking about PCCM or Illinois Health Connect (IHC) going away. It is the infrastructure that HFS built that we are asking you now to build a superstructure on top of. That is what CCEs are. We are not asking innovators to leave Illinois Health Connect to build a CCE. We are asking innovators to build a CCE on top of Illinois Health Connect. HFS is not eliminating IHC.

Public Education Subcommittee Report

Nelson Soltman from the Legal Assistance Foundation of Metropolitan Chicago (LAFMC) provided the report. The subcommittee last met on October 20th. The group received information about the Child Health Quality Demonstration grant awarded in 2010 to the joint proposal from Illinois and Florida under the Children Health Insurance Program Reauthorization Act (CHIPRA). The federal goals are to experiment with and evaluate promising ideas for improving the quality of children's healthcare under Medicaid/CHIP. CMS will establish a Pediatric Quality Measures program using information learned from CHIPRA demonstrations.

The department continues working on the initiative to eliminate the monthly issued paper medical card and replace it with a plastic card. The public target date is January 1, 2012. To make this change as smooth as possible, the department is creating an Automated Voice Response System (AVRS); which is a telephone number that clients will be able to call to determine whether, for a particular month, they or other family members are eligible. There was a detailed script reviewed and the department asked for comments by early November. The department has received comments and made some revisions.

Long-Term Care (LTC) rule making was also discussed by the subcommittee. The change in federal law Illinois is implementing under the rule is called the "look back" period for transfer of assets for individuals going into a nursing home. The look back period has been extended from 3 to 5 years from the admission date to the nursing home to determine if the asset transfer was appropriate or was solely for the purpose of becoming Medicaid eligible. The issue at the meeting was the process of communicating this change to the nursing home residents and their families. There will be a follow up meeting the first week of December with the department and at least the LAFMC and Age Options to offer our comments and suggestions on how this should be communicated.

There were updates on the HFS Hotline address change project, which is an effort to ease the burden on state workers with address change requests. Since the project began, there have been close to several thousand addresses changed via telephone rather than having the client go to a DHS local office.

There was a brief review of the All Kids Application Agents (AKAAs) statistics showing that 91% of AKAA filed applications are approved.

There was discussion about the Illinois Health Insurance Exchange legislative advisory committee, for which Director Hamos has already given an update on in her report today. The subcommittee also talked about the Medicare Improvement for Patients and Providers Act of 2008 called MIPPA, which deals with the enrollment process for seniors and persons with disabilities in programs under which Illinois pays for Medicare premiums, copayments and deductibles. The program is implemented, but as discussed, enrollments have been less than what was anticipated.

The last meeting item was a report from Ms. Ellinger on the eligibility verification and maintenance of effort. She stated that Illinois' Medicaid Reform law set two deadlines for HFS to change its standards for verifying income and Illinois residence. The principle expectation was that HFS would increase the number of documents required to those factors of eligibility. The department suspected that the federal government would find changing the requirements to be a violation of the Maintenance of Effort (MOE) provisions under the Affordable Care Act (ACA). The penalty for violating the MOE is very severe resulting in a loss of federal matching funds. HFS wrote to CMS and they responded that the changes would be a violation in that the State can't put a bigger burden on what documentation is required from applicants or recipients, but that we could enhance electronic and automated verifications for any of these factors. In December, HFS will start verifying Illinois residence for everybody who applies and also at redetermination. The principle information source will be the Illinois Secretary of State's motor vehicle registration and state identification database. HFS expects to get most of the cases confirmed through that system, but if residency can't be verified through this process, the department will look at using other sources, such as, child support payments or Social Security payments. If unable to verify Illinois residency through the sources that we have available, and the applicant/client/doesn't provide the required documentation, HFS would either deny or cancel the case. In addition, the department is also working with the Illinois Department of Revenue to obtain income information electronically. Although tax records do not provide the current month information, they will give some sense if a person's income is within the reported range. HFS hopes to procure additional income information from what we are calling an "income verification service provider" that collects income information from large employers and makes it available as income confirmation for persons who are applying for credit, bank loans or mortgages. Other states have tried this and HFS could buy this type of income confirmation. Although it will only verify some of the person's earned income, we believe it would be beneficial.

Diane Fager asked what other proof of residence would be used. Ms. Ellinger indicated that HFS is adopting proofs used for SNAP benefits, in addition to adding other documents and means, such as other states' Medicaid agencies. The department may be able to identify more instances where people are coming to Illinois solely for medical benefits. For example, a non-citizen applicant in Illinois on a tourist visa is not an Illinois resident. And, the use of electronic verifications will help us shore up our program integrity.

Jessica Williams asked if residency verification will be for each family member. Ms. Ellinger advised that the intent is to check the adult applicants on the case and deem the children eligible based on that, unless we have a reason to question a child's residency, which would warrant further investigation.

Ms. Montañez shared that some of her clients do not have the type of proofs that would be reviewed electronically. Her concern is proof for undocumented pregnant women. Ms. Montañez asked if there would be a list of other acceptable documents. Ms. Ellinger directed her to first look at what is out there for SNAP determinations, but that HFS would be issuing a new policy manual release in the near future. If a child is enrolled in school, the department can use a document that shows enrollment. Ms. Ellinger assured the group that the department will try to be flexible. For example, for a homeless person, a shelter may write a letter, or a landlord or other tenant confirming that a person resides at an address, would be acceptable.

Ms. Stapleton believes that the State's General Assembly (GA) didn't have an understanding of how complicated this verification process would be. She would hope that the department would keep track of how much the eligibility mandates costs in both time and additional contracting in order to find a small amount of people who are not eligible. In addition, the GA's demands may cause an unjustified burden on state workers.

X. Open to Committee

Director Hamos thanked Eli Pick for his years of service and in helping her along this path. She recognized his role as a leader in revitalizing the MAC. Chairman Pick thanked Director Hamos for her leadership as well.

Chairman Pick stated that regarding the report on Long-Term Care (LTC) eligibility, there are now some 70,000 people who are being funded through community care programs and not just nursing homes. He assumes the department would be applying that same standard to all applicants for LTC and that would include

people other than in nursing homes. Ms. Ellinger replied that HFS has posted a summary of the changes on the HFS website under Public Involvement. She added that the department welcomes input on how we explain these changes, as it is not an easy task.

Dr. Kirkegaard asked if there will be a provider notice to explain these changes as many of the patients get their healthcare information from their providers. Ms. Ellinger replied that she didn't have this on the HFS list, as our primary contact has been the elder bar, but it is a good addition for the list.

Christine Cazeau asked if there is a better date than January 1st for rollout of the durable medical card. Robyn Nardone answered that the department is waiting for the procurement process to finish before making the announcement of the vendor selected for the project. We will have a clearer idea on the actual date once we secure the vendor and are able to discuss the deliverables. As shown in the RFP on the State's procurement Web site, the card will include the beneficiary's name, recipient identification number and birth date. Each beneficiary will receive their own card.

Gary Fitzgerald asked when the answers to the coordinated care questions would be available. Mr. Parker advised that there were a couple of questions that require actuarial input; otherwise they are ready to post on the HFS Web site. If they are not posted today, they should be posted early next week.

Diane Fager shared that one of the things CPS does is to advertise other programs and is currently advertising the Earned Income Tax Credit (EITC) program. There are about 300,000 children enrolled in CHIP/Medicaid and CPS would be willing to partner with the department in getting a message out to families.

Ms. Eagleson stated that she appreciated all the work done by staff and committee members. She especially wanted to mention three committee members: two members, Jan Costello and Dr. Melissa Vargas, who will be resigning from the MAC and also Eli Pick, who has been dedicated in chairing and serving on the MAC so well for many years. Ms. Eagleson acknowledged their efforts and thanked them for their commitment to the people served under the HFS programs.

Chairman Pick extended a thank you to Director Hamos and commended her on her energy, the stimulus she has injected into this process and in impacting policy. He stated that the success of the MAC depends on the level of commitment and interest of the department and the persons around the table. He will be available and continue to have an interest, but his work as chairman has come to an end.

XI. Adjournment

The meeting was adjourned at 11:50 a.m. The next meeting is scheduled for January 20, 2012.

Illinois Department of Healthcare and Family Services
Division of Medical Programs

CMS Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

On July 8, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Directors (SMD) letter providing preliminary guidance on opportunities to better align financing between Medicare and Medicaid in an effort to enhance the quality of and reduce the cost of care for individuals enrolled in both programs ("dual eligibles"). The CMS outlined two models – Capitated and Managed Fee-for-Service (FFS) – to help States overcome the financial misalignment between these two programs and to pursue the integration of primary, acute, behavioral health and long-term services and supports for dual eligibles.

On September 30, 2011, the State of Illinois submitted a letter of intent to participate in both models. Below are highlights of the two models:

Capitated Model

- This model will test a capitated payment model utilizing a three-way contract among the State, CMS, and health plans to provide integrated benefits to dual eligibles.

- Plans – selected through a competitive, joint (CMS and State) procurement process – will receive a blended capitated rate for providing the full continuum of benefits across both programs.

- Participating plans will be required to comply with all applicable Medicare and Medicaid rules and regulations as well as program specific and evaluation requirements including established quality thresholds.

- Key objectives of the initiative are to improve access to care and quality, eliminate cost shifting between the two programs, and achieve cost savings.

Managed FFS

- Under the Managed FFS model, States will ensure seamless integration and access to all necessary services, based on the individual's needs, through coordination across the Medicare and Medicaid programs.

- The Managed FFS model is designed to build upon existing FFS delivery systems and new CMS programs that offer States opportunities to improve care coordination for Medicaid beneficiaries including dual eligibles (e.g. Medicaid health homes).

- The State will be eligible to receive – based on the State meeting or exceeding established quality thresholds – a retrospective performance payment based on the level of Medicare savings achieved net of increased Medicaid costs.

- State participation in the Managed FFS model aligns with the State's Innovations Project, which offers new funding incentives and flexibilities to engage community partners in facilitating coordinated, quality care, across provider and community settings to specific Medicaid populations including dual eligibles.