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: July 10, 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, July 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 and the draft minutes from the March 16, and May 18, 2012 meetings. Also attached is the draft Access Subcommittee Charge for review. 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

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

AGENDA

I. Call to Order

II. Introductions

III. Approval of March 16, 2012 and May 18, 2012 Meeting Minutes

IV. Director's Report

V. Review of Amendment to MAC Bylaws

VI. Review of Revised Draft Charge for Access Subcommittee

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

VIII. Update on Care Coordination Initiatives
- Innovations Project
- Dual Medicare/Medicaid Care Integration Financial Model Project
- 1115 Waiver Demonstration Project

IX. Open to Committee

X. Adjournment

Charge for the MAC's Access subcommittee
~~May~~ July 2012

The Access subcommittee is established to advise the Medicaid Advisory Committee concerning strategies for ensuring that populations covered under Healthcare and Family Services' Medical Assistance programs have timely access to quality care that meets their need without discrimination. The special focus of the Access subcommittee is addressing healthcare disparities regardless of race/ethnicity or socio-economic status.~~, primary language, geography or age.~~

This subcommittee will:

1. review access with areas of focus that may be programmatic or by specific population or health condition;
2. review steps that can be taken to improve access to care for Medicaid recipients via recommendations for more effective public education, change or refinement in quality indicators or identifying gaps in reporting access to care.
3. based on such reviews, make recommendations to the Medicaid Advisory Committee to improve programmatic implementation or population access and to also include recommendations to HFS on how to track progress or lack of progress in addressing gaps or service deficiencies.

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
March 16, 2012

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

Members Present
Susan Hayes Gordon, Chairperson
Kathy Chan, IMCHC
Eli Pick, Post Acute Innovations
Judy King, M.D.
Mary Driscoll, DPH
Linda Shapiro, ACHN
Karen Moredock, DCFS
John Shlofrock, Barton Mgt.

Members Absent
Edward Pont, M.D., ICAAP
Glendean Sisk, DHS
Sue Vega, Alivio Medical Center
Andrea Kovach, Shriver Center
Renee Poole, M.D. IAFP
Jan Grimes, IHHC

HFS Staff
Julie Hamos
Theresa Eagleson
James Parker
Jacqui Ellinger
Lynne Thomas
Robyn Nardone
Sally Becherer
Greg Wilson
Jaci Vaughn
Ann Lattig
James Monk

Interested Parties
Lindsey Artola, Presence Health
Victoria Bigelow, Access to Care
Dave Bilbrey, Meridian
Julie Billingsley, Magellan
Peter Blake, Merdian
John Bullard, Amgen
Kim Call, Biogen Idec
Kelly Carter, IPHCA
Joe Cini, AHS
Laurie Cohen, Civic Federation
Gerri Clark, DSCC
Diane Fager, CPS
Andrew Fairgrieve, HMA
Gary Fitzgerald, Harmony
Kathy Franklin, Access to Care
Pat Gallagher, ISMS
Susan Greene, SGA – HFS
Ann Marie Grimberg, HHO
Marvin Hazelwood, Consultant

Interested Parties
Joe Holler, IHA
George Hovanec, Consultant
Teresa Hursey, Aetna Better Health
Nadeen Israel, Heartland Alliance
Glenn Johnston, GSK
Emilie Junge, Doctors Council SEIU
Esther Jzoyville, FHN
Nicole Kazee, U of I Health Systems
Margaret Kirkegaard, M.D., IHC
Keith Kudla, FHN
Mike Lafond, Abbott
Dawn Lease, Johnson & Johnson
Dennis Majeskie, Johnson & Johnson
Randall Mark, CCHHS
Mona Martin, Vantus
D. R. McCale, Ipsen
Susan Melczer, MCHC
Diane Montañez, Alivio Medical Center
Caitlin Padula, Shriver Center
John Peller, AIDS FDN of Chicago
Susan Reyna, Beacon Therapeutic
Camille Rodriguez, IARF
Phyllis Russell, ACMHAI
Maria Shabanova, Maximus
Amber Smock, Access Living
Janna Stansell, HMPRG
Chester Stroyny, APS Healthcare
Mayumi Tukui, U Chicago Medicine
Peggy Velasquez, ICIRR
Jason Versaysk, Ipsen
Dave Vinkler, AARP
Jessica Williams, CPS – CFBU
Julie Youngquist, Lawrence Hall

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
March 16, 2012

I. Call to Order

Chairperson Gordon called the meeting to order at 10:07 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Approval of January 20, 2012 Meeting Minutes

Dr. King requested a correction on page 10, to read:

> "A motion was offered by Dr. King to recommend that HFS implement a policy/practice of identifying racial/ethnic, primary language, and geographic disparities in medical program enrollment, access, utilization and outcomes for HFS beneficiaries. In addition, she said that HFS should publicly report on its efforts to correct identified disparities. The motion was seconded but tabled right away by Dr. Pont for further discussion about this motion as part of the broader MAC priorities."

The minutes were approved with this correction.

IV. Director's Report

HFS Director Julie Hamos thanked Eli Pick for his work as MAC chairman recognizing his commitment and assistance in thinking through how to make the MAC an effective and involved group. She presented him with a certification of appreciation for his valuable years of service. Chairperson Gordon also presented a token of thanks from members of the MAC.

Director Hamos stated that HFS has been put in a very painful position of having to come up with spending and liability reductions totaling $2.7 billion. She wanted people to understand how real this crisis is. She hopes the cuts will be coupled with new revenues. However, legislators are not talking about new revenues. What brought HFS to this point is that for this fiscal year, the department was deliberately underfunded by almost $2 billion. This happened at about the same time that the enhanced federal match that HFS was getting for the last few years ended. At the end of this fiscal year, HFS will have about $1.8 billion in unpaid bills.

The Civic Federation used the department's budget numbers and created a 5-year plan which projected if the state didn't make recommended changes, there would be $22 billion in unpaid bills. Looking out 15 months by the end of the next fiscal year, the department will have $4.7 billion in bills on hand meaning that we will not be able to pay our vendors for a year. This undermines our ability to keep vendors and serve Medicaid clients.

HFS has been asked to put all potential eligibility cuts on the table with three program categories of reductions to look at. These include: 1) reducing eligibility for children from 300 percent to 200 percent of the Federal Poverty Level (FPL), which would impact only 19,000 out of the 1.7 million children enrolled; 2) reducing eligibility for family members enrolled in FamilyCare from 185 percent to 133 percent of the FPL, and; 3) reducing eligibility for state-only funded programs.

There is also a category of cuts called optional services, which are defined as services that the federal government doesn't require states to cover. Although referred to as optional, they were put in place to have less costly and more effective service. Prescription drug coverage for adults is an example of an optional service on the table to completely eliminate which represents savings of about $800 million. If all adult optional services were eliminated, the projected savings would be $1.9 billion. HFS hasn't identified any reductions in services for children.

Director Hamos stated that later today her team will present to the co-chairs of the legislature's Advisory Committee on Medicaid some utilization controls that might produce some additional savings.

HFS hasn't yet had the benefit of a public response. The director believes that providers and community advocates will suggest that HFS shouldn't make these cuts and would try to hold on to their piece of the Medicaid budget. It is difficult to imagine how the department could come up with $2.7 billion in cuts. The legislature would need to vote for some cuts and others may be done by rule changes. The director encouraged members to provide constructive feedback on cuts.

Chairperson Gordon and George Hovanec stated that the IHA and Children's Memorial Hospital have made recommendations to HFS related to cuts. Mr. Hovanec commented that recommendations have been made relating to eligibility controls and concerns with the passive rede process, the impact DHS' understaffing has on keeping people on the rolls too long, and also some potential savings in third party liability payments. Director Hamos indicated that she was not aware of these and would review the recommendations with staff.

Director Hamos noted the department's efforts and challenges, including the Maintenance of Effort requirements under the Affordable Care Act (ACA), to implement the state's Medicaid reform legislation and working with the federal CMS and state interagency agreements.

Diane Fager expressed concern that families with mixed citizenship status are now less likely to access programs and services because they are afraid to apply for Medicaid, as well as state-only funded programs.

Director Hamos advised that HFS covers about 50,000 undocumented children and spends about $52 million in general revenue funds to cover them. There are no federal matching funds. The director indicated that she had tried at the last meeting of the Advisory Committee on Medicaid to take this cut off the table, but didn't succeed.

V. Update on Innovations Project

Status of Solicitation
Director Hamos reported that February 29th was the deadline to submit Letters of Intent to participate in the Innovations Project for adults. About 70 letters were received. Some of these were duplicates and some didn't fit with what HFS is trying to do, but still this was a strong response. Sofia Newman is working with our data-mart and has set up six conference calls with six groups to discuss their data needs. The solicitation for coordinated care for children with complex health needs should be released in April or May this year.

Dual Medicare/Medicaid Care Integration Financial Model Project
There will also be a solicitation with CMS for dual eligibles coverage. The draft RFP is currently open for comment. HFS has identified two regions of the state to serve dual eligibles and may also include non-dual-eligible Medicaid seniors and people with disabilities (SPD) as part of the project. The program will include 150,000 to 200,000 persons in managed care.

VI. Proposed 1115 Waiver Demonstration Project to Cover the Uninsured – Cook County

Theresa Eagleson referred the group to the handout, *1115 Waiver Concept Paper - Cook County Health & Hospitals Systems*, (Attachment 1). She noted people may be aware of this waiver request as the information had been published in newspapers around the state. Given the unique way Illinois finances Medicaid health care services between the county and the state, where Cook County contributes half the resources to pay for the cost of care and as a provider has the single largest uninsured population served in Illinois, HFS was looking for a way to help the county prepare for both better care coordination in and amongst their facilities and with a broader group of providers, as well as bring in the federal money that will be allowed after 2014 to cover this uninsured population earlier.

HFS has proposed to the federal CMS an early expansion for uninsured people up to 133 percent of the FPL. The expansion would be financed only with the local county share and the federal dollars. The plan focuses on patient centered medical homes and gives the county and state a head-start in looking at this population prior

to 2014. Ms. Eagleson asked Randall Mark, of the Cook County Health & Hospitals Systems (CCHHS), if he wanted to add to her report or otherwise open the floor to questions.

Mr. Mark thanked the director and her staff for all their work that had started in 2010. It was inspired, in part, by what Cook County had observed in California where public hospitals were seeking a waiver that was ultimately granted and will bring about $600 million a year to California over the next 5 years. In consultation with HFS, CCHHS developed a proposal for a more stream-lined coverage expansion that gives the opportunity to build the care coordination infrastructure comporting with the aims of the Illinois' Medicaid Reform law and federal ACA.

Director Hamos added that since this is an eligibility expansion and because the Medicaid reform legislation required a moratorium on eligibility expansion, state legislative authorization would be required.

The following clarifications on the waiver demonstration were given by HFS.

1) A public notice is required for a waiver request. There is a 30 day period for written comments that ends on April 6th. Comments may be submitted on-line at: http://www2.illinois.gov/hfs/PublicInvolvement/PublicNotices/Pages/ShareYourComments.aspx
2) Although the waiver would decrease the magnitude of the problem with declining federal Disproportionate Share Hospital (DSH) payments, the problem doesn't go away. Cook County's uncompensated care is about three times the amount it receives in DSH funds.
3) The state is not handling any of the redesign of the Cook County system. It has not been determined if payments to Cook will be on a per member per month (PMPM) basis or a fee-for-service reconciliation. From an operational perspective, the state is not reimbursing the county for any of the set-up.
4) For the network, CCHHS expects to partner with other providers for the full range of services for this population. CCHHS anticipates reimbursing those providers directly.
5) Demonstration waivers are generally for five years but implementation of the ACA in 2014 means we may have to transition the waiver to a Medicaid plan in less than 5 years.

Nadeen Israel advised that Heartland Alliance is very supportive of the CCHHS waiver. She stated that her organization encourages the County to coordinate with regional providers, especially in areas of the County where there isn't sufficient access to primary care, mental health and substance abuse services. She also encouraged partnering with providers serving the AABD population.

Amber Smock, of Access Living, stated that many states are pursing similar 1115 waivers. The New Jersey and New Hampshire waivers will cover disability services. There is concern that the Cook County proposal doesn't include long term care, personal care or home health services. A comprehensive medical home should include these components as well as mental health and behavioral health services. Access Living supports the waiver and commends the state for acting on this now. However, further dialogue is needed. She offered to share policy papers on managed care principles for disability services from the National Council on Disabilities and testimony from Texas disability advocates on their state's 1115 waiver proposal.

John Peller, of the Aids Foundation of Chicago, provided a summary of written comments submitted, including a fact sheet outlining possible interactions between the waiver and Ryan White funded services. He stated that there is a HIV funding crisis with a proposed $4 million cut for next fiscal year resulting in a 50 percent cut in community based HIV programs including prevention. His organization believes there is an opportunity for some medication costs to be picked up by the federal government. There is also a concern that the Ryan White program which provides funding for uninsured HIV persons has very strict "payer of last resort" requirements. HRSA says these requirements can't be waived. In California, these requirements were disastrous in their 1115 waiver. Good coordination is needed in the Medicaid and Ryan White programs, so there's no interruption in care.

Emilie Junge, from Doctors Council SEIU, also submitted written comments. She stated that the council, along with SEIU Local 71, represents the bulk of the county employees. She stated that the union is fully supportive of the new care coordination patient-centered model and is working with leadership to make sure it is successful.

Eli Pick commented on the administrative burden created with "payer of last resort" where the denial of a claim is needed so that the payer of last resort will in fact pay. This should be taken into account so that if a bill is not covered under Medicaid it can be presented timely to the last resort payer.

Director Hamos commented that for this waiver, a network of services will be provided for these clients and Cook County will pay their bills. If providers come to HFS to pay the bills, there will be an edit in the department's system to forward the bill over to CCHHS.

VII. Follow-up Discussion on Committee Priorities for 2012

Chairperson Gordon stated there was discussion at the last MAC meeting on a number of ideas including Dr. King's tabled motion. She wanted to start today's discussion by reframing where we were and where we wanted to go. HFS' priorities are set by the Governor, Medicaid law and the Illinois General Assembly. The MAC can advise HFS on priorities, but must recognize that these are set in the broader arena of Washington and Springfield. Chairperson Gordon suggested that the MAC talk about the big priorities or topics and then send to appropriate subcommittees to work on.

At the last meeting, Ms. Eagleson shared that HFS' priorities are coordinated care, innovations, rate reform and the looming program budget cuts that it will have to implement. Chairperson Gordon stated that we are here to talk about the things that people relying on Medicaid really need to have. The broad topics are: mental health, health care disparities, adolescent health care, lack of specialty care for children and specialty care in general.

Chairperson Gordon asked if there were any additions to the list and opened the floor for comment. A thoughtful and lively discussion on priorities followed, as summarized below.

- There is a need to address how the community gets to weigh in on the programs and services that HFS is providing and how that input takes place.
- The specialty care topic is more about finding specialists for adults. There was a plan put in place to facilitate access in Cook County. The focus needs to be on reporting back to know that the plan is working. The emphasis is in knowing that over the years there are so many plans and we still see these disparities. Are people getting their appointments at Cook County now?
- Part of the conflict is separating policy from execution. When we put them together in a single discussion and when there is lack of execution, we go back to what is wrong with the policy. There may be nothing wrong with the actual policy, but rather how it was implemented. It would be beneficial to take the operational pieces and establish work groups to analyze those elements to determine where the gaps and breakdowns are occurring.
- Historically, the MAC has had a lot of data reporting, but very little programmatic review. We don't get to determine if we are getting value for the dollar. As an advisory committee, the intent was to provide input to HFS in saying we want to advise you on gaps, services that are missing in the total system, as well as those areas you are serving already and how can we improve that to make it better. We are trying to figure out how to effectively use the dollars available at a time when fewer dollars are there.
- There is a data component for coordinated care. The director of research has attended coordinated care meetings and is charged with helping get data out to the various groups trying to participate in Innovations.
- As these priority recommendations move forward through the various subcommittees assigned, HFS would also ask for a recommendation on how that subcommittee feels it is appropriate for HFS to track what they are

asking us to do. This is requested so HFS has a way to measure it on an ongoing basis and so the MAC may see the progress against that goal.

- The Care Coordination Subcommittee provided input to HFS as it moved forward with the innovations solicitations. The subcommittee is now looking at how to measure and improve quality.
- HFS is moving toward looking at performance and outcomes in terms of quality and not just quantity. It is more the charge of the Care Coordination Subcommittee to look at outcomes as the department is measuring this in many of the reports it is doing. Quality has to be linked to a program and linked to say how many clients are getting timely access to specialized care.
- In terms of adolescent health, it should tie into HFS' perinatal plan, as Medicaid pays for about 93 percent of teen births. In the CHIPRA report there are over 20 measures and the state reported on only seven. Some of those measures are adolescent measures. Adolescent health is listed as a priority, because the MAC hasn't heard much about it.
- Ms. Shapiro stated the topic areas are more evaluation parameters for understanding Medicaid program effectiveness. There are so many programs coming out of HFS right now with many changes. Maybe this is the time to say let's follow the "storyboard". If we have an innovation, then follow the storyboard and see if the innovation is effective.
- It goes to the issue of how you structure work. The move toward adopting organized systems of care is exactly the strategy the department has adopted to do a number of things such as addressing quality, access and financing. Care coordination affects all those things and is integral. This is clearly something HFS has adopted, with statue behind it, and with initiatives on the street. Populations have been prioritized to start with so it is not across the board yet, but it's moving in that direction. It would be helpful to know whether MAC members recognize that as the framework, as it is clearly all there.
- The department thinks about financing in Innovations as having our payment systems aligned with provider care and behavior. It is not a question of can we afford it, but how can we do it better or more effectively. The Innovations Project is about how we can redo and rethink our payment methodology.

Director Hamos indicated that she took the issue of children's mental health to the Human Services Commission. As part of their mission, they are creating a workgroup to look at this as more of a systems issue asking how it impacts the various systems and what do we really need to do to fill in the gaps. The process is just now starting as it requires multiple agencies sitting around the table. If adolescent health care is a priority for the MAC, then we should create a substantive committee around that and try to bring in all the players, such as school based clinics, to talk it through and figure it out on a system wide basis.

Kathy Chan stated that the IMCHC runs the Illinois School Based Clinic Coalition and would welcome conversations about these issues. There are a lot of groups that are present in the room and also may not have the opportunity to come to these meetings that are working on these issues. She suggested it would be great to come up with some concrete "asks" to bring back to the MAC or to a subcommittee. Ms. Chan noted that there is effective advocacy work, as well as substantive program work, going on outside the MAC and bringing it back to this venue would be helpful in moving forward.

Dr. King stated that her concern is looking at whether or not Illinois Medical Assistance program beneficiaries or potential beneficiaries are able to access and receive the care that they should receive. If there are barriers to adolescents getting that care, it is an issue for Medicaid. The insurer needs to be responsible for having those conversations and making sure programs are in place and working. She said a piece of this should be reporting.

Diane Montañez stated that she doesn't think the state is in the position right now to really explain follow up and quality. As the state moves into coordinated care and managed care, a lot more detail can be provided because the level of reporting and the level of accountability under these new systems is much higher than we have ever had. The state is not in a place right now to measure some of these service outcomes.

Mr. Pick summarized that Chairperson Gordon is trying to solicit a motion to establish some structure where subcommittees are given charges. He suggested that as a priority for the MAC our charge is to assure that populations that are being covered by Medicaid are receiving access to quality care in a timely manner that meets their needs. From there we can look to whether the area of focus is programmatic or by population or condition. The areas of focus begin to identify whether we are meeting that policy statement. For example, we have a committee like "Long Term Care" or "Public Education" and their charge has been in place to evaluate the programs. What we are saying is that we want to modify that charge to use this overarching policy to see whether from a programmatic standpoint the policy initiative is being met.

Director Hamos suggested that maybe we look to create a subcommittee on access. One could look at specialty care under that and could take it by population or by provider or service and do some very interesting thinking. We need to focus and find a place where we can really hone in on some of the priorities.

Ms. Fager suggested creating a "School Based Health" subcommittee, stating that there is much activity in CPS right now on this subject. It is a national phenomenon in many ways as schools are standing up to the plate for public health. We now have a new health officer at CPS, who will be reporting to the Chicago Dept. of Public Health and the head of CPS. There is a huge number of wellness initiatives being funded and implemented. CPS has a huge optical care program for children who failed their vision screening and somehow their HMO didn't pick up the cost.

Ms. Chan noted that there is a school health task force and that the IMCHC School Health Center director is on that task force. She could get more information and share it.

VIII. Discussion of Subcommittees

Chairperson Gordon identified the current subcommittees as Care Coordination, Long Term Care, Pharmacy, Public Education and Dental. It was suggested that the MAC to add two new subcommittees: Access and School Based Health. She suggested that school based health could be part of the Access Subcommittee. She asked how members would feel about creating a new Access Subcommittee and retiring the Pharmacy Subcommittee.

Mr. Pick offered a motion to sunset the Pharmacy Subcommittee. The motion was seconded by Ms. Driscoll.

There was discussion on HFS public involvement in pharmacy as a lot of people have concerns about accessing medication. Ms. Eagleson stated that the department has a Drug and Therapeutics Committee that has two parts, clinical and public. Director Hamos noted that this is part of HFS' public involvement and that MAC members could be invited to that committee.

- The seven MAC members present voted (six in favor with one abstention) to sunset the Pharmacy Subcommittee.

Mr. Pick made a motion to establish a new Access Subcommittee. The motion was seconded by Dr. King. Mr. Pick then suggested that the MAC chairperson and HFS consider who it would like for the new subcommittee chair and discussion with that individual include formulating a subcommittee charge that could be adopted by the MAC at the next meeting.

MAC members were polled to see if they would be willing to participate on the new subcommittee by attending and reporting the work of the committee to the MAC. Ms. Shapiro, Ms. Driscoll, Ms. Chan, Mr. Pick and Chairperson Gordon indicated a willingness to participate.

- The seven MAC members present voted all in favor of establishing a new Access Subcommittee.

Dr. King stated that her motion from the last meeting that had been seconded and then tabled had not yet been resolved. She said that the actions taken today still do not address her motion, which is about asking HFS to prioritize those inequities in a more explicit manner than it does.

Chairperson Gordon asked Dr. King to restate her tabled motion. Dr. King presented the motion as follows: "The Medicaid Advisory Committee recommends that HFS implement a policy/practice of identifying racial/ethnic, primary language, and geographic disparities in medical program enrollment, access, utilization and outcomes for HFS beneficiaries. In addition, HFS should publicly report on its efforts to correct any identified inequities and disparities.

Director Hamos stated that she agrees with what she believes to be the intent of Dr. King's motion. However, big important ideas have to be packaged in a way that HFS can really do something. Taking on health disparities is so big that it is hard to imagine that we would do it well, unless someone could focus it. Director Hamos explained that what was interesting about Dr. King's point is that for all these years Medicaid has been a fee-for-service system and now we have a very different reorientation of our mission. HFS has basically been letting people go out and shop for services, asking our provider community to figure it out, and then, hopefully, step up to the plate, send us the bill and we will hopefully pay it. She stated that HFS' approach today is different. And, with all of the state and federal mandates HFS is currently working on, Dr. King's suggestion needs a focus and a strategy behind it.

Ms. Shapiro stated that there is already some evaluative material that is being done that would just be an agenda item for the MAC. What Dr. King brings to light is that there is intent, a program is created and some money is spent. Then we have a report to look at. What we can look at as a group is the intent and the plan to evaluate. It brings up the idea of delivery of care and using the expertise around the table to reform delivery of care in any way we can evaluate through a narrow lens that has specific focus.

- The seven MAC members present voted two in favor, four opposed and one abstention. The tabled motion was not passed.

Mr. Pick asked if the group could go back to the policy statement he had raised about the current MAC charge. He suggested that the statement could be used as a prism to evaluate how access to quality care in a timely manner based on client needs fits with the existing MAC charge.

Chairperson Gordon read Section I of the MAC bylaws which states: "The Medicaid Advisory Committee (MAC) is created to advise the Department of Healthcare and Family Services (HFS), State of Illinois, about health and medical care services under the Medical Assistance Program pursuant to the requirements of 42 CFR 431.12 (e) with respect to policy and planning involved in the provision of Medical Assistance."

Director Hamos noted that the statement is under Article 1 – Name and Mandate. She suggested that we could add another section that is the MAC vision statement.

Ms. Ellinger added that making this change includes a notice requirement and should be published in advance of the MAC meeting to allow action to amend the by-laws. Ann Lattig could help with publishing. Also someone will need to help write the amendment.

Chairperson Gordon hoped that a motion to amend the bylaws could be brought up at the next MAC meeting. She summarized that today the MAC has made the access issue the new priority for 2012 and within that all the other issues fall. She stated that we looked at the subcommittees and created the new Access Subcommittee; and asked for a motion regarding the committee's intent to both amend the MAC bylaws with a vision statement and include it as part of the charge statement for the new Access Subcommittee with the following language: "To assure that populations that are being covered by Medicaid are receiving access to quality care in a timely manner that meets their need regardless of race/ethnicity, primary language, geography and age." Mr. Pick made the motion and Ms. Driscoll seconded.

- The seven MAC members present voted unanimously to accept the motion of its intent to amend the MAC bylaws with a vision statement and include the language as part of the charge statement for the new Access Subcommittee.

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
March 16, 2012

IX. Subcommittee Reports

Public Education Subcommittee Report

Ms. Chan provided the report. MAC members were provided a copy of the subcommittee charge that showed recommended revisions as track changes (Attachment 2). She advised that these changes were presented at the last subcommittee meeting. Input was solicited from committee members, as well as everyone who has been participating. Ms. Chan moved that the MAC adopt the revised charge. The motion was seconded.

- The seven MAC members present voted unanimously to accept the revisions to the Public Education Subcommittee charge.

Long Term Care Subcommittee Report

The report was deferred to the next meeting.

X. Open to Committee

Due to time constraints, the floor was not opened for discussion of new topics.

XI. Adjournment

The meeting was adjourned at 12:05 p.m. The next meeting is scheduled for May 18, 2012.

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
May 18, 2012

1919 W. Taylor Street, Chicago, Illinois
201 S. Grand Avenue East, Springfield, Illinois

Members Present
Susan Hayes Gordon, Chairperson
Kathy Chan, IMCHC
Mary Driscoll, DPH
Linda Shapiro, ACHN
Karen Moredock, DCFS
John Shlofrock, Barton Mgt.
Edward Pont, ICAAP
Andrea Kovach, Shriver Center
Renee Poole, IAFP
Jan Grimes, IHHC
Sue Vega, Alivio Medical Center

Members Absent
Alice Foss, IL Rural Health Assn.
Glendean Sisk, DHS
Eli Pick, Post Acute Innovations
Judy King, M.D.

HFS Staff
Theresa Eagleson
James Parker
Greg Wilson
Lora McCurdy
Ann Lattig
James Monk

Interested Parties
Scott Allen, ICAAP
Victoria Bigelow, Access to Care
Kathy Bovid, Bristol-Meyers Squibb
John Bullard, Amgen
Mary Capetillo, Lilly
Kelly Carter, IPHCA
Carrie Chapman, LAF
Geri Clark, DSCC
Laurie Cohen, Civic Federation
Kimberly Cox, Addus Healthcare Andrew Fairgrieve, HMA
Eric Foster, IADDA
Hala Ibrahim, Meridian
Nadeen Israel, Heartland Alliance
Nicole Kazee, U of I Health Systems
Margaret Kirkegaard, IHC
Keith Kudla, FHN
Mike Lafond, Abbott
Phillip Largent, LGS
Randall Mark, CCHHS

Interested Parties
Grace Martos, Molina
Susan Melczer, MCHC
Diane Montañez, Alivio Med Center
Joy Mahurin, CBDC
John Peller, AIDS FDN of Chicago
Mary Reis, DCFS
Phyllis Russell, ACMHAI
Bernie Stetz, Molina
Chester Stroyny, APS Healthcare
Dave Vinkler, AARP

Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
May 18, 2012

I. Call to Order

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

II. Introductions

Attendees in Springfield and Chicago introduced themselves.

III. Approval of March 16, 2012 Meeting Minutes

Chairperson Gordon stated that she would like to share and discuss some recent email comments from MAC member, Dr. Judy King regarding the draft minutes. The email had been sent to all MAC members.

Dr. King wrote that she wouldn't be present today to vote, but believed the draft minutes contained several errors and omissions. She wished to register her disapproval and surprise that in the vote to create the Access Subcommittee, she wasn't listed as an interested participant. She believed that there are issues concerning race and racism that should be addressed within HFS and the MAC. She also stated that a 10 day advance notice was not provided regarding the plan to amend the MAC by-laws, as the notice date was May 11, 2012.

Chairperson Gordon stated that in discussing with HFS staff, and her recollection of what occurred at the March meeting, was that when she asked for volunteers to serve on the Access subcommittee, she had a number of MAC members volunteer, but Dr. King wasn't one. She added that it made sense that Dr. King would want to serve as she has raised the issue of racial disparities for many months and that is why the MAC planned to amend the bylaws and create the new committee. Chairperson Gordon believed it was a misunderstanding and also that she'd planned to ask again today for volunteers to serve. Dr. King would be welcome to participate.

Dr. Pont asked if there had been further discussion with Dr. King regarding her concerns. Chairperson Gordon advised that she had not yet discussed it with her. She added that since 10 day advanced written notice wasn't provided on the amendment to the bylaws, action would not be taken by the MAC at today's meeting.

Members, Dr Pont, Andrea Kovach and Renee Poole advised that since they were not in attendance at the March meeting, they would abstain from any vote taken. Dr Pont noted that while there is a quorum present, without these voting members there wouldn't be enough members for the vote. He suggested that the approval of the minutes be tabled for the next meeting. The committee decided to review the draft March minutes at the next meeting.

IV. Director's Report

HFS' Medical Director, Theresa Eagleson, shared that Director Hamos was sorry she could not attend today's meeting and that she was glad to see so many attending today's meeting at the alternate Chicago location. She provided an overview of the ongoing budget process and what the department expects to come.

The state is entering the last stages of this legislative session. On some fronts, the department is pleased that some things are looking better, but there are still some pretty painful things going on with the large list of cuts the Governor put forth several weeks ago. The list of cuts has been reduced some, but there are both service and utilization cuts still being discussed. The Governor has proposed a cigarette/tobacco tax as a revenue source. If approved, it would take some of the pressure off the very large provider cuts that have been proposed. This is the good news. The department was looking at a potential 12 percent reduction to provider rates, but it may be closer to 5 percent. Ms. Eagleson encouraged participants to contact their legislators to support the cigarette tobacco tax (potential $750 million in revenue) as it will help minimize provider reductions.

The department believes it may be able to publish a next version of service and utilization cuts in the near future. Ms. Eagleson noted that the department has almost 70 new "projects" on that list to implement, with almost all of the changes being effective July 1, 2012. In order to implement, the department will be required to take action in the form of RFPs, administrative rule-making and changed to provider payment policies. You will see a public notice come out on the Illinois register as early as this Friday. The notice will have the bigger reduction numbers in it. There will probably be another public notice on June 1 that covers what is actually passed by the legislature. HFS will likely have a public hearing on the budget reductions all of this.

The department extended the due date for the Innovations Project solicitation and this was put on the HFS website a couple weeks ago. The department is still very excited about this project and has received some really great responses.

Dr Pont asked about potential rate changes for primary care services effective January 2013. He noted that there is a proposed rule out now about increasing rates for primary care codes up to Medicare levels with the feds picking up the difference. Dr. Pont asked for clarification on how this fits with the provider rate cuts that HFS is contemplating.

Ms. Eagleson stated that HFS is currently in discussion to exempt physicians, dentists and community health centers from the rate cuts because of existing court and federal mandates. The decision is still in flux, but there will be notice coming out in legislative form in the next several days, as well as a public notice later.

V. Review of Amendment to MAC Bylaws

Chairperson Gordon reviewed that the plan to amend the MAC by-laws would not be voted on today because of the timely notice issue. She hoped that the committee would review the draft amendment for the next meeting.

VI. Review of Draft Charge for Access Subcommittee

Chairperson Gordon reviewed the draft charge for the Access Subcommittee that was included with today's MAC meeting materials. She asked members for recommendations for any revisions in the draft charge.

Mary Driscoll wished to look at access with an eye toward reducing disparities in race and socio-economic status.

Linda Shapiro stated that it is good in some ways to narrow the focus to racial/ethnic and socio-economic disparities because people may face other types of discrimination that are not listed here. Ms. Shapiro suggested adding a period after the word "need" in the first paragraph and then adding a sentence to that the subcommittee will have a special focus on reducing racial/ethnicity and social economic disparities and access to quality care without discrimination. She asked that a revised draft charge incorporating today's discussion be distributed in the meeting packet for consideration of the MAC at the July meeting

Renee Poole started that she agreed with Ms. Shapiro's comments, but she would also like to add addressing healthcare disparities in the initial summary paragraph.

At the last MAC meeting, Ms. Shapiro, Ms. Driscoll, Ms. Chan, Mr. Pick and Chairperson Gordon indicated a willingness to participate on the Access Subcommittee. Chairperson Gordon stated that Dr. King was interested and asked if there was anyone else interested in participating. Sue Vega and Andrea Kovach also expressed interest.

Margaret Kirkegaard asked if the subcommittee is open to people who aren't currently MAC members. She

asked if someone could review how members of the MAC and the subcommittees are determined. She explained that she has had some persons interested in serving on subcommittees, but wasn't sure how the process works.

Ms. Eagleson stated that Director Hamos appoints members to the MAC and the process is outlined in the MAC bylaws. There has to be a certain number of members representing consumers of healthcare, as well as health providers. The MAC is authorized to create subcommittees and workgroups as it deems appropriate. The chair and members of subcommittees and work groups are appointed by the Chair of the MAC in consultation with HFS. HFS tries to follow the MAC bylaws in structuring the composition of the subcommittees. Voting membership is usually capped at 15 persons as larger groups can be unwieldy. Similar to the MAC, anyone is able to attend any one of the subcommittees and the department welcomes all input.

Chairperson Gordon read aloud Article II, Membership, Section 1from the MAC bylaws. She advised the committee that she and the department had just finished selecting new members for the Public Education subcommittee and, today, she would be sharing the names of those persons who have agreed to serve. She suggested that people contact Director Hamos if interested in volunteering for the MAC or any of the subcommittees.

VII. Subcommittee Reports

Long Term Care (LTC) Subcommittee Report
Neither department staff nor a MAC member that attended the last LTC meeting was available to make a report. The agenda item was deferred until the next MAC meeting.

Public Education Subcommittee Report
Ms. Chan reported that the subcommittee has been meeting every other month. At the last meeting, the group reviewed HFS notices sent to families with children in All Kids that would no longer be eligible effective July 1, due to the change made last legislative session to limit coverage to families with income only up to 300% of the FPL. This is the population that was "grandfathered" for one year. Members had an opportunity to comment that day as well as submit comments later. She noted that partners at Health and Disability Advocates are getting a lot of calls from families who have received the notices and are trying to figure out other ways they might find health insurance.

The subcommittee also discussed the Integrated Eligibility System and how HFS is moving forward with that.

The next Public Education meeting is scheduled for June 14th. Depending what happens with the Medicaid reforms there should be robust discussion. Clients are concerned about what they are hearing.

Ms Shapiro asked if the HFS website shows when there is a notice that goes out to families about Medicaid. She asked if MAC members could be notified when there is something new like this notice, as providers are communicating with families and it would be great to get that information out. She thought it would be beneficial for providers to see what is being sent to patients so we can prepare to help and fortify those expectations.

Ms. Chan stated that All Kids Application Agents (AKAA) receive bulletins when there are new things changing for clients or a need to update manuals. She is not sure if AKAAs get all the notices that go out to clients before they bring them in to walk through with them.

Ann Lattig stated that the client notices are maintained on the Department of Human Services (DHS) websites. She was not aware of electronic notification from DHS when new information is posted, but HFS could look into that.

Ms. Chan suggested that this could be brought up at the next Public Education Subcommittee meeting as a DHS representative is usually in attendance.

Chairperson Gordon shared the names of the persons that have agreed to serve on the Public Education Subcommittee. They are: Kathy Chan, Chairperson; Sue Vega, Alivio; Margaret Stapleton, Shriver Center; Henry Taylor, Mile Square Health Center; John Jansa, Progress Center for Independent Living; Margaret Dunne, Beacon Therapeutic; Cora Shaw, Client advocate; Nadine Israel, Heartland Alliance for Human Rights; Hardee Ware, Eastside Health District; Sonia McGrath, SIU School of Medicine; Diane Goffinet, Land of Lincoln LAF; and Paula Ramos, Community Healthcare.

She added that letters are going out thanking them for their willingness to participate. Also, everyone is invited to attend the Public Education subcommittee meetings.

VIII. Update on Care Coordination Initiatives Discussion of Subcommittees

Innovations Project

James Parker, Deputy Administrator of Operations, reiterated that the deadline for the Innovations Project solicitation was extended to June 15, 2012. The department received 75 Letters of Intent (LOI). HFS put out a notice informing people that the department would fund up to 10 entities in Cook County and 10 entities downstate. This is not a hard number, but gives people an idea of how many entities may be approved in this competitive bid process and in some cases encourages consolidation of proposals.

Dual Medicare/Medicaid Care Integration Financial Model Project

The federal CMS has posted the HFS proposal on their website for a 30-day comment period which ended recently. HFS has received a number of comments. The RFP for HMOs was posted at the beginning of this week. The department continues to work with CMS on this joint application process. CMS has an online system for HMO plans to apply. The deadline has passed for companies to file a LOI. The department received about 16 letters representing about 10 different companies. The plan is to announce the awards by the end of July.

The solicitation for coordinated care for children with complex health needs is still under development. Once the legislative session ends, the department can turn its attention back to this solicitation. HFS will have to wait to see what comes out of the legislature as far as managed care that may change the picture. As far as changes there have been a couple of minor things as far as mental health services being incorporated. There has been some discussion of time lines and speeding things up for managed care in general but nothing in writing as yet.

Mr. Parker addressed participant questions as summarized below.

Q: Kelly Carter asked if the list of companies that submitted letters of intent is available publicly.
A: When CMS initially sent the list it was identified as confidential, but now that the deadline has passed, we will have to check to see if it can be released.

Q: Chet Stroyny asked 2 questions. The department's RFP identified 136,000 dual-eligibles with 118,000 in the Chicago area and about 18,000 duals downstate. HFS talks about enrolling 5,000 a month once that process begins. 1) Does the department anticipate that once parties see the RFPs for the two geographic areas that some companies will choose not to file? 2) Does the department anticipate full enrollment at that number?
A: 1) Yes, there may be some who choose not to submit a proposal, as filing a letter of intent did not lock a company into responding to the RFP.
2) Total enrollment is really not known. The numbers represent potential enrollees that will be passively enrolled over time but since persons may voluntarily opt out HFS is not able to determine the enrollment rate.

Some people are thinking a rate as high as 80 percent. Some think, and Mr. Parker indicated he believed, that the rate will be lower.

Q: Dr. Pont asked about the final role of Illinois Health Connect. He suggested that the department come out with some definitive statement about its' long term role with that program either in terms of geography or patient population as it impacts providers transitioning to a capitated model. It would be helpful for providers to have some lead time to know what the landscape is going forward.
A: Mr. Parker stated that he understands the concern. In the end the final direction on what HFS will do and how fast will come from the legislature. In discussions this spring, the department has asked for a clear signal on how to proceed. The problem is that issues are tied together in so many ways that they are unable, for understandable reasons, to provide clear direction. Things like hospital rate systems, nursing home rate systems and Cook County financing play into the ability to go to capitation. IHC will not go away totally. It will shrink as more people go into capitation. There will likely be large areas in the state where IHC will be the primary delivery system, as well as for certain populations regardless of where they are in the state.
The Client Enrollment Broker RFP is posted now. Because of the need to score proposals and the pricing of proposals, HFS had to post a proposed managed care rollout schedule. There will be a Q & A posted with respect to that RFP. Mr. Parker warned that the rollout schedule is possible, and may be plausible, but should not be taken as a certainty.

Q: A meeting participant asked if the department has a broad sense of the number of lives that MCCN or MCE bidders hope to manage in their Innovations proposals.
A: Mr. Parker advised that HFS has tried to estimate a range for the number of lives to be covered by MCEs in the first full year of operation. The RFP requires an entity to cover at least 500, and for 20 entities the total lives covered would be about 10,000 at the low end. But, it's more plausible that the low end would be 50,000 and the high end in the area of 200,000.

Q: A meeting participant asked to the extent that there is a gap or difference between eligible lives and covered lives as a result of this project, can the department comment on what a plan might look like for the target population that doesn't get covered?
A: Mr. Parker indicated that when putting aside all of the issues that are involved in capitated managed care, HFS' plan would be to move the target population of seniors and persons with disabilities (SPD) to capitated managed care. We have the 50 percent law and have until 2015 to do it. After the legislative session the department can get a better idea of the number needed for 50 percent to be enrolled in managed care.

Q: A meeting participant asked if pharmacy is "carved-in" to the capitated program.
A: Mr. Parker clarified that it is currently in the Integrated Care Program and that Medicare Part D is under the dual eligible program and it would be included in any future RFPs.

Q: Keith Kudla asked for clarification on the Medicaid/Medicare Alignment Initiative RFP that describes awarding at least two, but no more than five health plans for each region, and an additional award to an MCCN that offers to implement the initiative in more than one county and whether or not the MCCN is in addition to the 5 HMOs?
A: Mr. Parker explained that HFS' plan is to have five plans in the greater Chicago area. If there is an MCCN, it would be one of the five. In central Illinois, there would be two plans and the MCCN would be one of the two. But, how it works out will depend on several factors. For example in central Illinois, if there is an MCCN that can only do a couple of counties, there would have to be at least three plans, as there must be at least two choices in every county. In Chicago, this will not likely be an issue.

Q: Keith Kudla commented on the Medicaid/Medicare Alignment Initiative RFP point scoring which asks about references from other states and experience in serving the target population. Since the MCCN is only in one state and may not have served the target population, one could argue that MCCNs may be 200 to 300 points in the hole as it is unable to respond to these questions.

A: Mr. Parker stated that the Q & A process for the RFP may be the best way to address this question. But, that there are ways for MCCNs to demonstrate their experiences. The department's goal is to find the providers that can best serve the population. Looking at people's experience is an important thing to do and as a new entity it can be hard to break in, but not impossible. A lot will depend on who the partners are in the MCCN and what they demonstrate they've done in the past.

Q: A meeting participant asked where HFS is in the creation of health homes in terms of your process and given the advocates' position now around the ability to draw down 90 percent Medicaid or community based services that come through health homes?
A: Mr. Parker explained that one consideration is that we don't want to go too fast on health homes because if we do, we'll lose the money. Once a state plan amendment is filed the 8 quarters start running. If health homes haven't been implemented widely, the 90 percent match is lost. Health homes will require new structures. The department can get the match through the HMOs and we have already had discussions with Aetna Care and Centene. But, the health home 90 percent match cannot be claimed in a geographic region, unless there are health homes available for everybody. Since the Integrated Care Program only covers a portion of our population, we can't file a state plan amendment until health homes are for every categorically eligible group, including dual eligibles, AABD, children and parents. This is why the department hasn't filed anything as yet. The Innovations Project is designed to create health homes for everybody. Health homes are only available for people with chronic conditions. Health homes will not be something separate from Innovations. Once we add the children with complex medical conditions and other things are in place with the CCEs, the department will be in a position to start claiming the 90 percent match.

1115 Waiver Demonstration Project
Greg Wilson, Chief of the Bureau of Program and Reimbursement Analysis, reported that HFS is continuing to negotiate with the federal CMS. They have formed their 1115 review committee. In the last couple of days, CMS has submitted questions to us covering network structure and finance issues. The department continues to push for a July 1st implementation date. CMS understands that our ability to do the eligibility expansion is contingent on amending state law. Randall Mark added that the legislative piece is active and that CCHHS has been asked to alter the original language drafted by HFS and the General Assembly. This is moving quickly and we hope to have something by May 31st.

IX. Open to Committee

Jan Grimes advised that she is a new MAC member representing the Illinois Homecare and Hospice Council (IHHC). She stated that IHHC took Director Hamos seriously when she asked for constructive input on the current budget cuts. IHHC is currently looking at a 10 percent cut. IHHC commissioned the Health & Medical Policy Research Group (HMPRG) to pull together a report on what had happened in other states when these services were cut. Ms. Grimes said that the report did get significant news attention yesterday and is posted on their website at www.Ilhomecare.org. The paper makes the case that when states cut back on homecare, their overall long term care rates went up. It makes sense that people seek emergency room or nursing facility care. The paper states that Illinois' rebasing effort needs homecare as part of its safety net so now is not the time to make the cut. She shared some copies of the press release and IHHC has shared the report with the legislature.

X. Adjournment

The meeting was adjourned at 11:15 a.m. The next meeting is scheduled for July 20, 2012.