Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee - March 8, 2013

Members Present
Kathy Chan, IMCHC
Mary Driscoll, DPH
Judy King
Margaret Stapleton for Andrea Kovach, Shriver Center
Eli Pick, Post Acute Innovations
Edward Pont, ICAAP
Renee Poole, IAFP
John Shlofrock, Barton Mgt.
Sue Vega, Alivio Medical Center

HFS Staff
Julie Hamos
Theresa Eagleson
James Parker
Arvind Goyal
Mercy Sanchez
Robyn Nardone
Debra Clemons
Molly Siegel
Mike Jones
Sally Becherer
Sameena Aghi
James Monk

Interested Parties
Greg Alexander, CCAI
Lindsey Artola, Presence Health
Chris Beal, Otsuka
Victoria Bigelow, Access to Care
Kathy Bovid, Bristol-Myers Squibb
Karen Brach, BCBSIL
Chris Breitzman, FHN
Laura Brookes, TASC
Libby Brunsvold, MedImmune
Nancy Carstedt, NAMI-CCNS
Kelly Carter, IPHCA
Carrie Chapman, LAF
Gerri Clark, DSCC
Laurie Cohen, Civic Federation
Mike Cotton, Meridian Health Plan
Autumn Davidson, University of Chicago
Deila Davis, Access
Mark Davis, Vertex Pharmaceuticals
Thomas Erickson, BMS
Gary Fitzgerald, Harmony-Wellcare
Jill Fraggos, Lurie Children's Hospital
Judith Gethner, IL Partners for Human Service
Lucen Gomez, IlliniCare HP
Kathye Gorosh, Consultant
Dean Groth, Pfizer
Steve Gustafson, Molina Healthcare
Lee Hasselbacher, University of Chicago
Marvin Hazelwood, Consultant
George Hovanec, Consultant

Members Absent
Susan Hayes Gordon, Chairperson
Jan Grimes, IHHC
Karen Moredock, DCFS
Linda Shapiro, ACHN
Glendean Sisk, DHS

Interested Parties continued
Ollie Idowu, Molina
Marissa Kirby, IARF
Mary Kaneaster, Lilly
Kiernan Keating, Takeda
Vijay Kotte, Meridian HP
Dawn Lease, Johnson & Johnson
Helena Lefkow, MCHC
Dan Lichtenstein, SEIU 73
Mona Martin, PHRMA
Randall Mark, Cook County HHS
JoAnn Mason, Meijer
William Mills, CSG
Diane Montanez, Alivio
Phil Mortis, Gilead
Divya Nagpal, CBHC
Heather O'Donnell, Thresholds
Kristen Pavle, HMPRG
John Peller, Aids Foundation
Melissa Picciola, Equip for Equality
Ena Pierce, HealthSpring
Sam Robinson, Canary Telehealth
Phyllis Russell, ACMHAI
Dee Ann Ryan, Vermilion Co. MHB
Ken Ryan, ISMS
Amy Sagen, UI Hospital & HS system
Heather Scalia, Humana
Christina Scurtu, Byram Healthcare
Amber Smock, Access Living
Sam Smothers, MedImmune
Jo Ann Spoor, IHA
Brian Stratton, WellCare
Joe Summer, Novo Nordisk
Bernadine Stetz, Molina Healthcare
Johnathan Thombeni, Byram Healthcare
Erin Vaughan, Astra Zeneca
Erin Weir, Age Options
Ericka Wicks, Health Management Associates
Nicole Willing, Mylan
Laura Zeiger, IlliniCare

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

I. Call to Order

MAC Vice-Chair, Kathy Chan chaired the meeting. She called the meeting to order at 10:05 a.m.

II. Introductions

MAC members and HFS administrative staff in Springfield and Chicago introduced themselves.

III. Approval of January 11, 2013 Meeting Minutes

Susan Vega asked for a typo correction on page 2, Old Business by changing the sentence to read, "These dates were posted on the MAC website. With this change, the January minutes were approved.

IV. Director's Report

Director Hamos introduced several new HFS staff including Dr. Arvind Goyal, Medical Director, and Debra Clemons and Molly Siegel, working with the HFS innovations project.

Director Hamos walked the committee through a HFS Fiscal Year Budget Overview PowerPoint presentation that was recently given as part of a human services briefing by five state agencies (HFS, DHS, DCFS, DPH and DOA) following the Governor' speech announcing the Illinois FY2014 budget. The PowerPoint presentation is online at: http://www2.illinois.gov/hfs/SiteCollectionDocuments/FY2014BudgetBriefing.pdf

Some highlights of the presentation are summarized below.

- More money will shift from individual provider group line items to a Coordinated Care line item.
- Current Medical Program Enrollment (11/30/12) at 2.75 million persons of which 1.67 million are children.
- Anticipate adding 69,100 ACA new eligibles and 33,800 Existing eligibles enrolling in FY2014 post ACA.
- Expecting 2 million person enrolled in coordinated care/managed care by the end of calendar year 2014.

- Colbert consent decree allows 500 Cook County nursing facility residents to move to community settings.
- Applied for Balancing Incentive Program for enhanced federal match for home/community based programs
- Medical liability estimated to grow by 3.9% with initial ACA enrollment. (2.2% growth without ACA).

- Primary care physicians may apply for a 2 year rate adjustment increase to the Medicare rate level.
- Provider information on applying for the rate adjustment at http://www.hfs.illinois.gov/html/030413n.html
- If every PCP signed up the increase in PCP payment is estimated at $600 million a year.

- SMART Act assumed $1.6 billion savings in 62 program reductions. HFS expects to achieve $1.1 billion.
- The projected budget for FY14 ($10.2 billion) is less than the budget in FY11 ($10.4 billion).

- Senate Bill 26 authorizing expansion of Medicaid under the ACA passed on a vote of 40 to 19.
- The Illinois uninsured population is estimated at 1.1 to 1.2 million citizens and legal residents.
- ½ will qualify to buy health insurance in the "State Partnership Marketplace".
- ½ will qualify for Medicaid coverage based on income. (If the General Assembly approves)
- In Illinois, 509,000 persons are expected to enroll in Medicaid by CY2017.
- 2/3 could be newly eligible adults (342,000) and 1/3 (167,000) could be eligible currently but not enrolled.
- Favorable federal match for newly eligibles could bring $12 billion to Illinois between 2014 and 2020.
- Requires up to $570 million spending to providers by Illinois between CY2014 and CY2020.
- Illinois' cost for the eligible but not enrolled group for the initial 6 months is estimated at $28 million.

Director Hamos reviewed the status of the ACA implementation. Of the 509,000 estimated to enroll by CY2017, about 241,500 are expected to enroll by June 30, 2014. New recipients must enroll in coordinated

care/managed care. The first phase of the new Integrated Eligibility System is being implemented and should be done by October 1. The name of the new eligibility system is Application for Benefits Eligibility or ABE. HFS is adding 47 headcount in FY14 to implement ACA. The Director asked for any questions or comments.

Q: Dr. Edward Pont noted that HFS is expecting 2 million persons enrolled in coordinated care/managed care by the end of 2014. Could HFS break the numbers down by age, geographic area and whether members are new or established in order to show how many established recipients will move to care coordination? He would like information to show how many people in say Du Page County that will need to move to a new plan from their current plan. This would help to prepare current providers in working with multiple care coordination entities.
A: Director Hamos suggested that the Department would present such a list. She also referred to a new handout that shows Care Coordination Roll-Out by Health Plans by program, entity name and roll-out date

Dr. Judy King commented that it would be helpful to have a narrative explanation of the budget. She would like to see more discussion in the budget on what is purchased in a way that is more directly related to the care that people receive. She would like to be able to see how budget reductions or increases relate to services received.

Director Hamos responded that the Department is not reducing amounts but are moving around line to create a budget for care coordination. There is a 2.2% growth in the new budget. She noted that the Department should be able to explain the change in the line items and the movement to greater managed care enrollment.

Susan Vega noted that there was a reduction in persons eligible for Medical coverage from the Department. She referred to the Illinois Cares Rx program.

Director Hamos agreed that last year there were $1.1 billion in reductions as a result of implementing the SMART Act. The new budget would not reflect the previous year's reduction.

Theresa Eagleson, Medical Programs Administrator added the reason that some of the line items are decreasing is that last year the Department had additional funding to pay down bills on hand. This year the amounts are more constant. This makes it appear that appropriations are changing when programs are not changing.

Heather O'Donnell suggested that as dollars are moved from different departments to care coordination that the Department figures out a way to show the funds are transferred from a sister agency to HFS.

Director Hamos responded that the change should be reflected in the sister agency's budget. The money should be separated out with a line item called care coordination.

Q: Dr. King stated that one of the bullet points under managing Medicaid budget growth was Expand cost-sharing by clients. Can you indicate how cost sharing will be expanded?
A: Director Hamos answered that HFS is at the limit of what it can use for cost sharing. That bullet point is trying to reflect for people looking at the full scope of what we had to do to bring the budget into balance last year. James Parker, Deputy Director of Operations stated that when HFS amended its rules last year for copays, it had put in the federal maximum nominal copay that was $3.65. It has now gone up to $3.90 for this year. He stated that once notices go out, most likely in April or May, the copay amount will go up to reflect the new federal maximum. He added that there is also a notice of proposed rule-making put out by the federal CMS to revamp the CFR provisions relating to copays. We may see some changes based on federal law in making copays. It also may have some effect on what we do next year.

Q1: Dr. King asked how HFS plans to measure the impact of the temporary rate increase for physician recruitment physicians and increasing capacity. **Q2:** What are the plans are for Illinois Healthy Women (IHW)?

A1: Mr. Parker stated that HFS would measure impact by looking at: 1) Getting newly enrolled physicians; 2) More billing by infrequent billers and 3) Increased billing by frequent billers. Director Hamos added that the first thing is to see the extent that providers sign up for the enhanced rates.

A2: Director Hamos stated that over a number of years there are programs that have been offered to persons that do not have insurance or couldn't get coverage for a pre-existing condition. IHW is one of them. The Department plans to put together a package of those and approach the legislature about helping to transition people into private health insurance on the "State Partnership Market Place". They may get subsidies from the federal government or if income is at or below 133% poverty coverage under Medicaid.

Ms. Chan thanks the Director for her report and reminded members that this is just a proposed budget and that the final budget may look differently.

V. IMRP (formerly EEV)

Bill Mills reported that the Illinois Medicaid Redetermination Project (IMRP) formerly known as EEV is now in production and has been online since January 2. In the last three weeks, IMRP has been in a measured full production, averaging review of 5,000 cases per week. This is below the capacity that HFS wants to run at but volume has been held down to be able to troubleshoot any problems with the system. The vendor has been very responsive. Many of the issues that come up are resolved the same day. There is a great deal of documentation for every transaction. Technical issues or customer concerns are dealt with on a case-by-case basis. Maximus will respond with individual or group training as needed. The process is healthy in how it improves itself over time. We are also getting feedback from caseworkers and looking at issues of processing the recommendations.

As cases flow through, the state has received about 6,600 recommendations. There are three main status types. These are: 1) Continue the case as is; 2) Change the case from one program to another, and; 3) Conditions no longer warrant continued eligibility. Mr. Mills stated that if there is concern regarding a particular client, this can be reviewed by contacting the call center and providing the name, RIN and contact information. The vendor staff will review and work to rectify any problem. He asked if any questions.

Q: Director Hamos asked when the first report would be on the website. If a case is recommended for cancelation will the report breakdown the reasons?
A: The first report will be online soon and definitely before the end of the month. It will show the number of cases cancelled and a breakdown of the reason for the cancellations.

Q: Kelly Carter asked if IMRP could also track when the contractor recommends termination and then the caseworker recommends continuation.
A: That will be tracked. It is a multi-layered query so more complex and would lag a couple of days.

Q: Eli Pick asked if statistics would be reported on appeals filed and the outcomes.
A: Mr. Mills advised that he is at a bit of a disadvantage on this as it lies beyond the scope of the project. He would think there would be a way to determine the activity. Director Hamos added that developing an appeals report is an important recommendation and that the Department should look into that.

Q: Dr. King asked what happens if people do not respond to communications from IMRP. If a client receives a letter asking for a response by a particular date and the client doesn't respond, would they be cancelled? There was in her view some inconsistent or confusing information from DHS and HFS about what happens to a client's enrollment when they don't respond within ten days.
A: The client wouldn't be cancelled following the missed date but Maximus would make a recommendation to terminate benefits. The caseworker has 20 days to evaluate that and to make a determination. If the caseworker should get additional information, it would be applied to the case to make the determination. Also if there is information that comes into the vendor after the recommendation to close, it will be shared with the worker via a flag statement on the portal. The statement indicates that new information was received and that the caseworker should review to see if this new information would override the cancel recommendation.

Director Hamos stated that the Department is trying to wait until the last possible moment to allow the client to establish eligibility and avoid cancelation. The time frames are set in law and clients should be encouraged to respond to correspondence. However if there is no response the case would be cancelled.

Ms. Vega noted that Alivio clinic staff sees people getting letters showing a due date before the date the letter was received. There can be a problem with the mail system in poor communities and this is not the client's fault. As advocates for our clients, we need to be aware of trending and track this type of problem.

Director Hamos responded that she believes that every person who has worked on this and every provider would say that keeping people from getting canceled is an important goal. It is a hassle for the client to show up. It is a hassle for the provider. It is a hassle for the state to re-enroll the client. It is a problem for maintaining continuity of care. This is why the Department is approaching this in a systematic way.

Margaret Stapleton commented that one thing that makes this more difficult is that people don't know when they come up for redetermination.

Director Hamos added that what also impacts our clients is that the Department is discontinuing the monthly medical card which has given providers the eligibility information they are looking for. HFS will take a look at the letters. She stated that the letter asking for information is where the "may" and "shall" can appear regarding the need to cooperate to avoid termination. A key is that the redetermination is an annual review.

VI. Prior Approval (PA) Issues with Prescriptions

Mr. Parker stated that one of the things that had been asked for was to pull together a sample of 20 randomly picked individual PA requests. Lisa Arndt had worked on putting that together but unfortunately could not attend the meeting today. She will have the report for the next meeting.

Mr. Parker was able to confirm the time frames for prior approval requests. The call hold time is three minutes or less. The Department enters data for either a phone or faxed request within an hour. The time from data entry to a prior approval pharmacy decision is within two hours. The entire process is less than a three hours.

Some people say that they are spending hours on the phone everyday with this process so how can HFS say the phone time is only three minutes. HFS found that the hours on the phone do not reflect hold time but the volume of client requests from a provider. HFS encourages those providers to use the online system as it is a little faster.

FY13 Medicaid Pharmacy program document

Director Hamos highlighted a couple of the program statistics. The number of adults with more than 4 scripts has decreased **41%** since August (194,600 vs. 122,800). The number of adults with more than 10 scripts decreased **80%** since August (7,000 vs. 1,400). The total Four Script Override Prior Auth Requests YTD was **133,000** (84,000 approvals/49,000 denials). She noted that there is several specific case examples included that show the types of prior approval requests received and the positive impact the process can have on patient's healthcare.

Mary Driscoll stated that this is an important program and that people with a lot of prescriptions deserve a review of their medication. However, there is a lot of confusion in the provider community about this. She has received calls at the IDPH Division of Safety and Quality from some providers why they can't have patients on more than four drugs. She would like to see more publicity about this policy as a review and not a strict limit. She would also like to see the waiting time on the phone improved and the process more timely.

Phyllis Russell made a request that as HFS looks at the specific cases that it makes a point of including those with behavioral health/dual diagnosis issues for persons receiving psychotropic medications. She would like to take a look at how well this is working for clients receiving both behavioral health care and primary healthcare.

Mr. Parker advised that the department could look at that. He noted that HFS staff had a meeting with a couple of legislators particularly on antipsychotics and this policy. HFS is looking at specific reasons for denial to improve the prior approval process. People should be aware that the online denial reasons are fairly generic and there is a phone number to call to speak to a pharmacist for more specific information on a denial.

Q: Ms. Chan asked what the wait time was to reach a pharmacist. If the inquiry is made by phone or fax, does the information come back to the provider?
A: Mr. Parker advised that he needed to check on this for her as the calls go directly to staff at UIC.

Q: Dr. Renee Poole asked if there have been any reports of adverse responses due to the medications limit or delays in receiving that medication. She agrees there is still some confusion on the 4 script policy for both providers and patients. The term, "limit" adds to the confusion. She was glad to see the specific examples of the quality mechanism put into place.
A: Dr. Goyal responded that HFS hasn't heard of any safety issues or irreversible situations. HFS has heard of one hospitalization that could have been avoided. HFS has also heard of some confusion on the policy but this is decreasing every month. He would welcome participants to share specific cases for review by the Department.

Dr. King stated that she supports the Department's drug use review. She would like to see HFS breakdown the data further to better see things that effect cost and savings. Things to look at in the utilization statistics would include age, basis of eligibility, increased use of generic drugs, effect of higher copays and changes in dispensing fees. She would also like to see some regional breakdown in pharmacy access and use based on race/ethnicity and legal resident/undocumented status.

Director Hamos asked that Dr. King put together her requests in an email so the Department could review them and let her know whether or not it can do the things that she is requesting.

Dr. Goyal thanked Dr. King for her thoughtful comments. He stated that the prior approval limit on drugs is evidenced based, especially with the geriatric population. He noted that while cost cutting is important, the review process is done to improve communication among providers and improve the quality of care for patients.

Health and Quality of Life Performance Measures
Mr. Parker reported that the Department has received some additional feedback on the performance measures. People have suggested a lot of good things to measure but the problem is can HFS actually measure them. HFS will need to meet with our sister agencies to begin to finalize the measures. HFS wants to use surveys but know if a survey is too long, people will not complete it. UIC is doing the evaluation for the Integrated Care and MMAI programs. They do conduct some separate surveys or focus groups. HFS is looking to see if some of the things suggested are covered by what they are doing. Comments on the performance measures may still be submitted online to the Department at HFS.ICP@illinois.gov.

Informational Notice
Ms. Eagleson stated that the Information memo dated October 26, 2012 regarding the Four Prescription Policy was included with the meeting notice to show how HFS is communicating with providers on this topic. Mr. Parker noted that the Department is referring to the process as the Four Prescription Policy and not using the term Four Prescription Limit. He added that this policy is for adults only and not in effect for children.

VII. Subcommittee Reports

Access Subcommittee Report: Mr. Pick reported that the committee met in mid-February. The Department presented the benefit package for the newly enrolled. The committee discussed looking at the experience with the Cook County 1115 waiver and how we could benefit from that information. It was decided to invite a representative from Cook County to present on some of the barriers that they experienced. The committee also decided to invite managed care organizations to present on their internal performance measures to see how their own internal monitoring could potentially reveal barriers to access for new enrollees. Rather than schedule

meetings bi-monthly, it was decided to wait and see the response to the new benefit packet and whether the committee could identify access barriers to discuss. The group is not likely to meet again until May or June.

Long Term Care (LTC) Subcommittee Report: Ms. Eagleson advised that there has been no LTC meeting since the last report. The next LTC meeting is in two weeks.

Public Education Subcommittee Report: Ms. Chan reported that the committee met on February 14. The group discussed the current transition from a monthly medical card that shows coverage dates to an annual medical card that doesn't show eligibility. This will impact the providers as they will need to check eligibility another way. This move will cut down on the cost of mailing and lost mail. Local offices are no longer issuing temporary medical cards so do not refer clients for one. The provider notice may be found on the Department's website at: http://www2.illinois.gov/hfs/MedicalProvider/MedicalCard/Pages/default.aspx

Ms. Chan stated that Brian Gorman of the Market Place team that is now at the Governor's office made a presentation to the committee and will participate on an ongoing basis. Also, the Maximus contract for the Illinois Monthly Redetermination Report is a standing agenda item. The next meeting is April 11.

Care Coordination Subcommittee: No one was available to provide the report.

VIII. Update on SMART Act 2840

Mr. Parker reported that under the SMART Act the Department eliminated group psychotherapy for nursing home residents as a covered service. The implementation of that overtook something else that was in the works which was to clamp down on abuse of how group psychotherapy was done and what HFS would pay for. The Department had a small problem with an FQHC that was billing for that and so HFS put together a similar rule for the FQHCs. The Department has since received significant feedback on one part of the rule that required a portion of each session to be conducted by a psychiatrist. The Department doesn't see a pattern of abuse by the FQHCs and committed to revise that rule. Now group therapy sessions conducted by FQHC clinics may be conducted by psychologists and licensed clinical social workers without requiring a psychiatrist.

The Department met with the Illinois Primary Health Care Association (IPHCA) and a member of both the senate and the house in the former Legislative Medicaid Advisory Committee (LMAC). The Department was asked that the application of the 340B policies in the SMART Act as they apply to contract pharmacies continue to be put on hold. HFS would try to look for a different option to realize those savings.

There also continues to be discussion with that committee on the Four Prescription Policy as it applies to antipsychotics. There is now a bill in the legislature to change that policy. At this point, there is no consensus on whether to support it or not but there is an amendment in Senate Bill 1807. The current draft of the bill would exempt antipsychotics and anticonvulsants from prior approval when treating schizophrenia, bi-polar disorder, PTSD and panic disorder.

IX. Update on Care Coordination Initiatives

Innovations Project: The Department is working with the CCE awardees to get them up and running. Right now HFS is focusing efforts on three of the CCEs because of the regions they are in and the fact that HFS is moving toward mandatory managed care enrollment in those regions this summer. The three CCES include Macon County, Precedence in the Quad cities area and Community Care Alliance of Illinois in the Rockford area. The Department is very impressed with the work that these providers have done to get ready for this roll-out and is encouraged that it will see some solid results from these organizations.

Dual Medicare/Medicaid Care Integration Financial Model Project: The Department has officially received the MMAI award from the federal CMS. The Memorandum of Understanding (MOU) was signed at the end of February. HFS is moving forward with implementation and meeting regularly with plans. The Department is setting up broad stakeholder meetings every other month starting in April. HFS is working with CMS to see what their participation will be and looking for the best venue to hold the meetings

Cook County 1115 Waiver Demonstration Project: As of this week there are 1500 persons enrolled in County Care but there are thousands more applications in process. They are getting about 500 applications daily. The County is doing their best to get those applications complete and forwarded to DHS. HFS expects the enrollment numbers to be growing exponentially in the next month or two. HFS is working to get the University of Chicago under contract to help with the evaluation of this project. February was the first month that people were enrolled for coverage. County is taking the opportunity to enroll people with a PCP when they initially apply even though they are not officially enrolled for health benefits.

Dr. Poole added that FQHCs are also onboard with this. Other hospitals are also coming onboard. Also once a person's application is pending it is being backdated to the date the application was initiated.

Dr. King requested that in respect to this waiver and other projects, it would be appreciated if the contracts could be posted and made available. Dr King stated that she has tried with Cook County to find out who the behavioral health providers are. The MMAI contracts should also be public. With the MMAI, while the MOU is available there is an addendum that is not available from the federal CMS as yet. The MOU makes reference to the addendum. She would like to review network adequacy as it will be one of the features on the Market Place as people choose their plan. In general it is difficult to tell what level of coverage there is under these plans.

Mr. Parker responded that he will check the website to see what is missing. Ms. Eagleson stated that the MMAI contracts have not been signed as yet but would be posted with the exception of information that is proprietary. She added that Ms. King would need to check with Cook County as their contracts are with them.

Q: Ms Stapleton asked if a report or information on the Cook County waiver's experience with establishing eligibility for people will be shared with the people who are doing the Market Place and enrollment throughout the state. She believes that there is a lot to learn there about what works or does not work.

A: Ms. Eagleson advised that a lot of people involved in bringing up the IES and ABE and the Market Place are directly involved with this project too. Documenting observations is a good suggestion.

X. Open to Committee

Ms. Chan identified a handout, "MAC Suggested Agenda Items" that was included as the last page of the meeting notice. She explained that this is list of agenda items that had come up at previous meetings that have not yet been discussed. She encouraged the members and audience to provide feedback on the list or make suggestions for other things that members would like to discuss.

Director Hamos stated that the next MAC meeting is May 10. She suggested that perhaps a presentation by Brian Gorman of the Market Place team may be of interest to learn of preparation for the marketing strategy to be used for the new market place.

Diane Montanez suggested the opportunity for providers to discuss with HFS their efforts to get agreements with the new MCOs and care coordination agencies coming into the city. She would be willing to help the HFS to identify entities that could be invited.

Mr. Parker noted that the HMOs have agreed to get together. They are exchanging documents in order to try to standardize as much of the process as possible in contracting, utilization review and billing. HFS then plans to open it up to meet with providers to see where there are issues and where we can make things easier.

Ena Pierce from HealthSpring stated that her organization stepped into the role of the spokesperson for the MMAI group. She has just received a list of the key contact persons in the group. The first discussion will be around standardizing billing for community mental health services as we do not want providers to have six or eight different ways to interface with us. The group will get together to talk about practical administrative needs and see if there is a standardized set of requirements that we can do. Ultimately there may be other opportunities around credentialing, standard forms, referrals and authorizations. We plan to solicit feedback from the provider community starting first with mental health.

Director Hamos suggested that this may be more appropriate to the Care Coordination subcommittee.

Lee Hasselbacher with the University of Chicago stated that she would like an update on the change in policy for family planning devices like IUDs and implants. She has heard from non-FQHC providers that there is difficulty in stocking those devices as they are expensive.

Mr. Parker stated that the Department should talk more about that. The FQHC fix doesn't avoid the problem of having to stock the devices as they are only allowed to bill for them. He is aware of at least one manufacturer that is interested in finding another approach.

Ms. Chan asked Mr. Parker whom within the Department someone may follow up with on this issue. He suggested that the person email him with background information. He advised that HFS needs to talk further with the manufacturers to see if they are willing to help with the situation.

Ms. Eagleson wished to acknowledge the work of Andrea Bennett who has the graduate intern who has been working with the Department for the last year and a half and has helped with keeping you informed about all these meetings. Unfortunately, she is leaving next week but she has found a great opportunity for her. We will try to replace her in the near future.

Ms. King stated that she would like to see the committee discuss reproductive healthcare and how it relates to access. What she is hearing about the IUDs and group psychotherapy is that decisions are being made without an assessment of the impact on the community. She would also like to see some portion of the agenda where there is commentary by the Medical Director and also some commentary on rules and legislation.

Lindsey Artola with Presence Health stated that if Brian Gorman of the Market Place team doesn't present at the MAC but at one of the other subcommittees, she would like to know about that. She also commended the Department on the chart showing the Care Coordination Roll-Out by Health Plans. She asked if there was a calendar or time lines showing when RFPs were coming out for persons interested in further CCE development.

Mr. Parker responded that the issue of future CCEs entering the market is something we will need to work out.

XI. Adjournment

The meeting was adjourned at 12:05 p.m. The next meeting is scheduled for May 10, 2013.