

Illinois Department of Healthcare and Family Services

Medicaid Advisory Committee

January 21, 2011

401 S. Clinton Street, Chicago, Illinois

201 S. Grand Avenue East, Springfield, Illinois

Members Present

Eli Pick, Chairman
Susan Hayes Gordon, CMH
Kathy Chan, IMCHC
Arnie Kanter for John Shlofrock, Barton Mgt.
Mary Driscoll, DPH
Sue Vega, Alivio Medical Center
Judy King
Linda Diamond-Shapiro, ACHN
Margaret Stapleton for Andrea Kovach, Shriver Center
Edward Pont, ICAAP
Jan Costello, Illinois Home Care & Hospice Council
Karen Moredock, DCFS
Melissa Vargas, AAPD Head Start DHI

Members Absent

Myrtis Sullivan, DHS
Alice Foss, IL Rural Health Assn.
Renee Poole, IAFP

HFS Staff

Julie Hamos
Theresa Eagleson
James Parker
Lynne Thomas
Jamie Tripp
Stephanie Hoover
Kelly Cunningham
Sally Becherer
Robyn Nardone
James Monk

Interested Parties

Michelle Baldi, CMS
Lauren Hoff, Legal Assistance Foundation
Robin Scott, Chicago DPH
Ken Ryan, ISMS
Pat Gallagher, ISMS
Kathy Bovid, , Bristol Myers, Squibb
Michael Lafond, Abbott
Joe Winalski, Biogenidec
Geri Clark, DSCC
Matt Werner, Consultant
Jo Ann Spoor, IHA
Chester Stroyny, APS Healthcare
Citseko Staples, Harmony/Wellcare
Mary Capetillo, Lilly
Libby Brunsvold, MedImmune
Kiernan Keating, Takeda
Doug Schenkelberg, Heartland Alliance
Mandy Ungrittanon, Quest Diagnostics
Lora McCurdy, IARF
George Hovanec, Consultant
Marvin Hazelwood, Consultant
John Bullard, Amgen

Illinois Department of Healthcare and Family Services

Medicaid Advisory Committee

January 21, 2011

401 S. Clinton Street, Chicago, Illinois

201 S. Grand Avenue East, Springfield, Illinois

I. Call to Order

Chairman Pick called the meeting to order at 10:07 a.m.

II. Introductions

Attendees in Chicago and Springfield introduced themselves.

III. Review of the Minutes

Edward Pont recommended two changes. With these revisions, the November 2010 minutes were approved.

IV. Director's Report

HFS director, Julie Hamos, provided the report.

Health Care Reform: Director Hamos provided participants with a fact sheet on the Medicaid reform legislation (Attachment 1) and reviewed some of the key initiatives in the legislation.

- Effective July 1, 2011, verification of the eligibility for the Medicaid and All Kids programs tighten by requiring proof of one month's income and proof of Illinois residency and effective October 1, 2011, eliminating passive redeterminations.

The redetermination change will affect an estimated 300,000 cases. Director Hamos noted that verification of eligibility changes are really part of the planning for Medicaid expansion three years from now under ACA.

- Limits the All Kids program to children in families with incomes no greater than 300% of the Federal Poverty Level and extends the All Kids program, that was due to expire, by another five years to 2016.

The income limit changes are effective on July 1, 2011. Children covered on that date will have another twelve months to find other insurance. This will affect 3,000 - 4,000 children. The department wanted to "grandfather" in these children until 2014, but was only authorized for one year.

- Requires that the State enroll 50 percent of medical program assistance clients in "coordinated care" by 2015. "Coordinated care" is defined to include a full range of health care and support services around the needs of the client, using care models other than just traditional managed care organizations.

There are about 200,000 in voluntary managed care today and the number would increase to about 1.5 million. The current PCCM model would not be considered coordinated care, as the legislation requires more risk to be assumed by the provider to be considered coordinated care. The department hopes to enhance the existing PCCM model and keep the medical home concept. There was discussion about defining coordinated care and concern that it not be completely a traditional capitation based managed care.

Jim Parker discussed the department's current proposed rule which allows the start-up of the Integrated Care Program, under which 40,000 AABD enrollees will choose a managed care plan. The rule is broadly worded to allow the department more flexibility in testing other care management models.

Director Hamos stated that a good agenda item would be to look at principles of care coordination. She stated the department would focus on quality of care and having people stay

Illinois Department of Healthcare and Family Services

Medicaid Advisory Committee

January 21, 2011

401 S. Clinton Street, Chicago, Illinois

201 S. Grand Avenue East, Springfield, Illinois

healthy and that healthy people cost less. She advised that this includes making better connections in discharge planning for hospitalized enrollees.

- Reforms the prescription drug program by: reducing prompt payment interest rates for pharmacy bills (from 2% to 1% per month); increasing co-payments, and; promoting 90-day maintenance prescriptions and utilization controls.
- Requires HFS and Department of Human Services (DHS) to create a state plan for improving existing management systems, with more data matches for eligibility verifications and increased efficiency of enrollment procedures.
- The department is working with the Departments of Revenue and Employment Security, as well as the Secretary of State's office, to complete data matches so more eligibility verification may be done electronically. The departments are creating an interagency coordination plan that will be submitted in the next six months. Major work is needed to reform the management information systems.
- Requires HFS, DHS and Department on Aging (DOA) to create a "unified budget" for long term care that will facilitate transitioning clients from institutional to community-based settings. Long term care rebalancing will look at the whole concept of services provided in various long term care settings.
- Enhances restrictions and civil penalties for recipients who abuse the system.
- Establishes a 2-year moratorium on Medicaid and All Kids eligibility expansions.
- The Medicaid reform legislation will result in cost savings and cost avoidance of an estimated \$624 - \$774 million.

Judy King wanted to know how cost savings of Medicaid reform would be made. She expressed concern that if a person didn't make a copayment, they would not get service, which could have a clinical impact. There was discussion on collecting copays for prescription drugs. Some participants expressed concern that enrollees would not have prescriptions filled if they were not able to afford the copays. Mr. Parker advised that the copays under Medicaid for brand name prescriptions are \$3 or less. There is no copayment for generic drugs and some brand name drugs, for example anti-psychotics, don't have a copayment. He added that for children there are copays for prescriptions under All Kids, but not under Medicaid. It was suggested that the department track if a hospital readmission is based on non-compliance in taking prescriptions. Director Hamos stated that the department would like to incent some pharmacy on prescriptions that are filled versus not filled.

V. Review Handouts #'s 3 through 8 from November 19, 2010 meeting

The handouts were reviewed by Mr. Parker. These included:

- # 3 Illinois Health Connect Quality Indicators (Primary Care Case Management)
- # 4 Illinois Health Connect Provider Profile (4/1/09 through 3/31/10)
- # 5 Your Healthcare Plus Clinical Measures for Elderly and Disabled Populations
- # 6 Child and Adolescent Care and Adults Access to Preventive/Ambulatory Care Measures
- # 7 Preventive Screening for Women and Maternity-related Measures
- # 8 Chronic Conditions/Disease Management Measures

Illinois Department of Healthcare and Family Services

Medicaid Advisory Committee

January 21, 2011

401 S. Clinton Street, Chicago, Illinois

201 S. Grand Avenue East, Springfield, Illinois

For the Provider profile (Handout #4), Jim Parker stated that each PCP received their report electronically and that the reports are based primarily on claims data from the department's Data Warehouse. He noted that while handouts #6 through # 8 compared two managed care organizations (MCOs), the department does have measurement data for Illinois Health Connect (IHC) providers as well. He recollected that the IHC measurements were a little better than shown for the MCOs.

Mr. Parker stated that working with measurements can get complicated as some measures are affected by variables such as how long patients are in the system. He added that the department received significant input from stakeholders on what measures to track. Theresa Eagleson advised that the department is looking at presenting profile data in an annual report in an aggregated way.

Ms. King was interested in measurement outcomes for providers other than MCOs. She identified some discrepancies in standards and omission of indicators from the provider profile compared to the measures on other handouts. There was discussion on how data is collected and indicators and standards identified. There was interest in more uniformity in the indicators and measures. Linda Diamond-Shapiro stated it would be right to do data source realignment and make sure that priority measures are aligned with the medical home goals.

Michelle Baldi stated that the federal CMS is looking at some 51 measures and that the department would see more guidance at the federal level. She gave an example of New York state focusing on lead screening as children's access to lead paint is a concern there. She stated that measures should be tied to health plans and other delivery systems beyond fee for service and MCOs.

Chairman Pick noted that some data conflicts have been pointed out and discussion has raised some questions. He suggested that perhaps the department can think about how to address via an internal assessment and report back to the group.

VI. Meeting Schedule Frequency and Topic Formulation

Ms. King made a motion that the committee go back to meeting six times a year rather than only quarterly. Dr. Pont seconded. There was discussion on adding special topics for extra meetings and the availability of members to attend additional meeting. The motion was called and approved on a 6 to 2 vote. Chairman Pick asked that the department propose some additional meeting dates.

VII. Subcommittees Reports

Public Education Subcommittee Report: Ms. Chan provided the report. She advised that the next meeting is on Monday, January 24th from 1:30 pm to 3:30 pm. Discussion continues on moving to the durable plastic medical card. The committee will be looking at a provider flyer, brochure and samples of the card. Robyn Nardone recommended that participants look at the meeting materials posted online.

Long Term Care Subcommittee report: Kelly Cunningham reported on the subcommittee meeting held on December 17, 2011. Key issues discussed included nursing home rate reform and creation of additional home and community based options to further the state's long term care rebalancing strategy.

Senate Bill 326, which proposed widespread nursing home reform, passed last summer. In accordance with provisions of the legislation requiring a study of nursing home rate reform, the department appointed a workgroup. The workgroup met multiple times between July and November of 2010, culminating in legislation (Senate Bill 3088) to implement the committee's work related to the creation of a nursing home assessment being passed during the veto session. The legislation also addressed nursing home staffing, funding for staff survey staff and funding for community services.

Illinois Department of Healthcare and Family Services

Medicaid Advisory Committee

January 21, 2011

401 S. Clinton Street, Chicago, Illinois

201 S. Grand Avenue East, Springfield, Illinois

It was asked if 14 percent of bed tax revenues will go to fund home and community based services. Ms. Eagleson stated that much of the 14 percent set aside will and that the amounts are written into the bill.

Creation of additional home and community based services for individuals currently residing in nursing homes who seek to return to their homes and communities is a major long term care issue facing the state. Ms. Cunningham stated that development of a home and community based waiver to serve individuals with serious mental illness is under discussion. Additionally, major class action lawsuits are driving many significant policy developments in long term care.

- The *Williams v. Quinn* consent decree requires transition of individuals from nursing facilities classified as Institutions for Mental Disease (IMDs).
- The *Ligas v. Quinn* lawsuit will address transition of persons with developmental disabilities currently residing in private ICF/DD settings.
- The *Colbert v. Quinn* lawsuit encompasses persons of all disability types residing in nursing homes in Cook County and their desire to transition to a community setting.

Lessons learned through the state's implementation of the Money Follows the Person program play a key role in program design associated with nursing home transition programs.

Director Hamos stated that this year will be the year for hospital and nursing home rate reform.

The LTC Subcommittee's next meeting is scheduled for March 11, 2011.

VIII. Adjournment

The meeting was adjourned at 12:05 p.m. The next MAC meeting is scheduled for March 18, 2011.



Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

MEDICAID REFORM LEGISLATION

Public Act 96-1501 [HB 5420, Senate Amendment #2]

This landmark legislation was the initiative of bipartisan Senate and House Special Committees on Medicaid Reform, with the support of Governor Quinn's administration. It includes numerous provisions that will improve the integrity of the Medicaid program, enhance healthcare for Illinois' children and families, and result in cost savings and cost avoidance of \$624 million – \$774 million over 5 years.

Among other initiatives, the legislation:

- Tightens verification of the eligibility for the Medicaid and All Kids programs by requiring proof of one month's income (by July 1, 2011), proof of Illinois residency (by July 1, 2011), and annual redeterminations of eligibility (by October 1, 2011), subject to federal approval.
- Places an income limit on eligibility for the All Kids program (beginning July 1, 2011) to children from families with incomes less than 300% of the Federal Poverty Level (about \$66,000 for a family of 4); also extends the All Kids program that was due to expire this year to 2016.
- Requires that the State enroll 50% of medical program assistance clients in "coordinated care" (by January 1, 2015) — defining "coordinated care" to include a full range of health care and support services around the needs of the client, using care models other than just traditional managed care organizations.
- Reforms the prescription drug program by reducing prompt payment interest rates for pharmacy bills (from 2% to 1% per month), increasing co-payments, and promoting 90-day maintenance prescriptions and utilization controls.
- Requires HFS and Department of Human Services (DHS) to create a state plan for improving existing management systems, with more data matches for eligibility verifications and increased efficiency of enrollment procedures.
- Requires HFS, DHS and Department on Aging (DOA) to create a "unified budget" for long term care that will facilitate transitioning clients from institutional to community-based settings.
- Enhances restrictions and civil penalties for recipients who abuse the system.
- Establishes a 2-year moratorium on Medicaid and All Kids eligibility expansions.
- Reforms the budget process by phasing out the practice of allowing unpaid bills from one year to be paid in the next fiscal year.