

**Illinois Department of Healthcare and Family Services
Medicaid Advisory Committee
Subcommittee on Access
February 15, 2013**

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

Members Present

Chairman Eli Pick, Post Acute Innovations
John Bouman, Shriver Center
Kathy Chan, IMCHC
Jan Grimes, IHHC*
Thomas Huggett, M.D. Circle Family Healthcare
Nadeen Israel, Heartland Alliance
Zakiya Moton, U of C Medical Center *
Heather O'Donnell, Thresholds

HFS Staff

Julie Hamos
Sharron Matthews
Arvind Goyal
Mike Koetting
Gabriela Moroney
Robyn Nardone
Sally Becherer
James Monk

DHS Staff

Michelle Saddler, Secretary

Interested Parties

Carrie Chapman, LAF
Mathew Collins, HealthSpring
Paul Frank, WellCare*
Katie Galle, Meridian Health Plan
Marvin Hazelwood, Consultant
Veronica Mihahan, Thresholds
Karen Mosley*
Michael Murphy, Consultant
John Peller, Aids Foundation of IL
Ena Pierce, HealthSpring
Cynthia Waldeck, Heartland Alliance

Members Absent

Malba Allen, Consultant
Andrea Cooke, LCSW, Student
Linda Diamond-Shapiro, ACHN
Mary Driscoll, IPDH
Melissa Gutierrez, Sinai Urban Health Institute
Susan Hayes Gordon, Lurie Children's Hospital
Margaret Kirkegaard, M.D. IHC, AHS
Hong Liu, MAHA
Malik Nevels, IAACP
Luvia Quinones, ICIRR
Randy Sadler, Youth 1st Counseling

* Some individuals participated via telephone.

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1. Call to Order

Chairman Pick called the meeting to order at 12:00 p.m.

2. Introductions and Housekeeping

Participants and Healthcare and Family Services (HFS) staff in Chicago and Springfield introduced themselves. Participants on the telephone introduced themselves.

3. Review of Minutes from 1/15/13

The minutes from the January 15, 2013 meeting were approved with none opposed and no abstentions.

4. Legislative Update and Eligibility Verification Project

Nadeen Israel provided the legislative update. She stated that SB26, Medicaid financing for the uninsured, would be heard by the full senate during the week of February 25th. She was fairly comfortable that the bill would be passed in the senate but believed that there is not enough support yet in the house. The house is set to reconvene next week and there will be some opportunity to educate members. Director Hamos added that support for a Medicaid expansion is increasing and becoming more bipartisan with support from some Republican governors.

Ms. Israel stated that what advocates are telling legislators about the services package is that it will be determined by rule and that essentially HFS will be the one doing that. It will mirror the FamilyCare package with a 10% increase as we think the newly eligible will be sicker than current FamilyCare folks. She believed that this is the best way to answer legislator questions about the service package.

Michael Koetting, Deputy Director for Planning and Health Reform implementation advised that everything we had said about the Enhanced Eligibility Verification (EEV) project last time is still more or less true except that we are about a month behind. We had the call center up and started reviewing cases but we found that the computer system didn't work well. We found some particular problems to fix as we had been forced to move quickly and had virtually no time for testing. There was a problem on the HFS side with abstracting data. There were more problems on the HMS vendor side which has struggled to get HFS the data and get the portal. It turned out to not be as done or as flexible as claimed. Maximus met all of its deadlines.

The project is now fully in gear. The Department did 200 test cases in January which turned out to be very instructive in learning about the process. We found out that some people were ineligible based on their own admission that they had moved out of state. This segment of people that appeared to live out of state was 15,000 out of an overall data match of 1.4 million persons. In some cases we found someone with the same name in another state but it was not our client. We found a very small number of cases in doing the overall data match where it looks like their SSN might not really belong to them. These persons are referred to OIG.

One advantage of going slow in January was that it has given DHS a chance to get further along in its staffing up process. A major issue with this project was that we would get these cases but the caseworkers would not have time to work them based on attrition or shortage of staff.

DHS Secretary, Michelle Saddler added that DHS has staffed up. There is a centralized office and unit to begin accepting the referrals and recommendations from Maximus and HFS. DHS will have hired 200 persons by the end of February to work EEV. DHS continues to worry about staffing and to bring people on at a pace that exceeds our attrition rate. Getting people up to speed is an issue as the newly hired don't know everything up front. We're taking experienced caseworkers for the central unit then backfilling. It's a challenge but HMS having some problems has actually worked to our advantage.

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Mr. Koetting stated that HFS has built a staffing model that looks at how many caseworkers we are going to have available and titrating the flow to match the number of caseworkers. We have built in a ramp-up time for training and believe we will be able to push through high numbers by the end of spring or summer. The biggest chunk of disenrollment will probably be in March, April and possibly into the month of May.

He noted that the Department has posted material on the HFS website that includes the basic letters used to contact clients and FAQs at <http://www2.illinois.gov/hfs/MedicalCustomers/eev/Pages/default.aspx> . The website page is called the Medicaid Redetermination Project. HFS knows that a lot of this may change, so we ask for your comments. HFS can make changes as we get a better handle on the things that are most important to the providers, advocates and the clients.

Chairman Pick asked if the Department is going to be able to produce some kind of data on the most common reasons people are dropped off and would the committee be able to look at that. Mr. Koetting advised yes. Director Hamos confirmed that data reports on this project would be posted on the website.

5. Review of covered services for Family Health Plans

Gabriela Moroney provided a handout listing the 26 items in the medical service package available to adults under the Department's FamilyCare health plan. She shared that these are the basic services that HFS envisions including as part of the alternative benefit plan to be established as part of the new eligibility category. She invited the subcommittee to review them and share feedback or comments.

There was thoughtful discussion on how to use the Medicaid service package list. There were suggestions to make the list more informational for providers and clients by adding definitions for target areas like mental health, substance abuse and post-stabilization services. More detail like any age requirement or who is eligible for community based and/or institutional services was requested for mental health and substance abuse services. It was suggested that the list have more detail to reflect the impact of utilization controls on things like pharmacy services, adult podiatry for diabetic adults only and emergency dental care. It was noted that chiropractic services will not be covered under FamilyCare and should be removed from the list. Chairman Pick asked if there was any service gaps perceived in the FamilyCare benefits.

Director Hamos reviewed that the handout shows the Medical Service package. What is not included are the Long Term Services and Supports that includes Home and Community Based Services waivers and nursing home services. HFS learned in our early conversations that it was more complicated and not as important to provide these. HFS heard consensus that this newly eligible population with complex behavioral health needs coming into the Medicaid program needed mental health and substance abuse services. Once assured that these were included, the Department thought the FamilyCare service package would be a good one to offer. Basically, HFS determined the FamilyCare per-member, per-month amount and added 10 %. This is not based on any actuarial analysis at this point. We felt there would be somewhat higher cost but needed services would be in this package. Director Hamos advised that SB26 states the Medical Service package determination would be done by rule and just reference FamilyCare and not spell out the benefit plan.

John Bouman added that it is useful to remember that the more this benefit package mirrors existing Medicaid, the less strangeness there is for members and providers in going back and forth between old and new Medicaid. It would be easier to maintain providers serving everyone.

Chairman Pick stated that the conceptual model discussed at the last Access committee meeting was attempting to chart all the services that were needed and to identify which were covered in the service

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packages and which were not. The Medicaid Services package handout helps as it delineates what would be covered under the Medicaid benefit for the expansion population

Ms. Moroney advised that an update would be made to the list.

6. Subcommittee planning

Areas of focus

Much of the meeting time was spent trying to pin down the areas of focus. As Director Hamos noted on the one hand access is such a big word that it includes everything, and on the other hand it is so big it is hard to narrow and focus and get strategic on what the right direction is here.

About ten topic areas were discussed. Some of the discussion is summarized under the following headings: Navigational chart for the HFS website, State supported non-Medicaid services, Other services not state supported, Person-centric or organization-centric focus, Advocacy for services, Provider and member training needs, Reporting access issues or problems, Learning about access from other providers, Increasing capacity and access, and Enrollment and Care Coordination as an Access issue.

At the end of the discussion, Chairman Pick summarized the group's decisions. It will look at access as organization-centric and specifically look at services offered under Medicaid. The specific areas of concentration are enrollment and care coordination. The complementary areas are training for new providers and new individuals who are going to get coverage and on how to use the benefit. He saw the next steps as inviting organizations to make presentations on their experiences and then formulate a specific plan of action.

• *Navigational chart for the HFS website*

Chairman Pick stated that the committee could create a chart with an X axis for population and Y axis for services. Subcommittee members represent constituent groups as interested parties and advocate for the benefits that our populations need. Those services that are within the medical service package are identified in the chart as well as those services that are not. Organizations may then share the way they access the uncovered service outside of Medicaid benefits. The chart becomes an informational tool to be posted on either the Medicaid website or the associated organization website as a link. An individual or advocate looking for a benefit is then able to see where they can go to find out more about that benefit.

Chairman Pick suggested that the committee focus more on the process rather than spending time on the mechanics. He suggested that the retool be done outside the committee via email or telephonically and to garner input from different people via email including input from constituencies that aren't necessarily sitting around the table. We would establish a deadline to collect information. The website would become the central place to collect information that everyone interacts with.

Assistant Director Mathews stated that for the legislative process that perhaps this tool would be used for people to advocate for filling gaps. She is hearing two things. One is having an ongoing tool that advocates can use on behalf of their clients to know where to get services and what is covered. The other is tied to advocating during the current legislative process. She suggested that one thing to do is update the chart of the 63 items identified under Medicaid reform by providing an explanation of the utilization controls.

Director Hamos stated that if the Medicaid expansion legislation passes then everyone that provides services to the group will have to become Medicaid providers. At that point, HFS anticipates a need in doing some

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comprehensive Medicaid program training. She believes that what the group has been talking about for the website would be too basic to be valuable to anybody.

- *State supported non-Medicaid services*

Secretary Saddler reviewed that DHS is just one of the agencies that provide non-Medicaid services with 200 programs and 2,300 providers. She didn't know what percent overlapped into Medicaid but believed it is a lot. This is both a Medicaid and non-Medicaid issue. DHS has shared a list with HFS and would be happy to share it with the committee. She added that Director Hamos has also received a list of service covered by the Illinois Department on Aging. Part of the message is that although these non-Medicaid services are in much smaller dollars than Medicaid, they are still vital to people's well-being.

Ms. Israel stated it would be helpful to know what the state supports in terms of non-Medicaid services. She requested that the list of grant based services that could be Medicaid would be provided at the next meeting assuming it is something that the group should be able to understand.

Director Hamos asked if people know of providers who currently give services to non-Medicaid clients only and are not in the mix of knowing what Medicaid offers. Ms. Israel identified free clinics like Heartland Human Care services. Dr. Huggett identified Heartland Community Health on Chicago Ave. John Peller identified agencies that provide case management for persons that are HIV positive that are primarily non-Medicaid agencies.

Secretary Saddler stated that her understanding is that there is a need to 1) Enhance referrals to facilitate client access to services that are not Medicaid covered and; 2) See if some service could be medicaidized. She noted that Director Hamos went through this exercise with a number of agencies in anticipation of the second phase of the Integrated Care Project. This project was happening very quickly and we couldn't change the waivers to include new services. The MAC could make recommendations on services that should be changed over to Medicaid or recommend a State Plan Amendment.

Director Hamos stated that this is an exercise that the general assembly has also conducted as they believed that if there is this group of newly eligible Medicaid clients then there are a lot of currently non-Medicaid supported GRF services that could and will be medicaidized. At the time, the state didn't think of that many services that are just GRF and could be medicaidized.

Secretary Saddler asked Mr. Bouman if review of the programs to enhance referrals and see what could be made Medicaid was still of interest.

Mr. Bouman responded yes but if you made a list of the things that can't be covered by Medicaid that pretty much is the list. He stated he was not sure that the group needed to go through seeing what is covered in order to find out what is not covered. He stated that for him the big access issues are eligibility, the work force, the pay rates that can get providers in the system, and identifying areas where people with a Medicaid card seeking a covered service can't get access to it.

- *Other services not state supported*

Mr. Peller stated that the issue for some providers is there is no category under which to bill for Medicaid related services. Case management like helping people apply for benefits and making sure they can get and keep appointments to access services are not currently Medicaid reimbursable. These could be reimbursable under a targeted case management through a state plan amendment. He believes that there are ways that Medicaid can pay for such services and that advocates would be interested in having the MCEs provide them.

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Director Hamos responded that this is a different approach. For example, probably 2 of those 200 non-Medicaid services are domestic violence services and permanent supportive housing. What Mr. Peller mentioned was different. He identified targeted case management services that are not covered but could be covered by Medicaid.

- *Person-centric or organization-centric focus*

Chairman Pick stated that the question to us as a workgroup is our focus person-centric or organization-centric. If it is organization-centric it is Medicaid and our charge is to determine what services are offered to what populations and how do they access them.

If it is person-centric, the charge is what are the needs of this population, which parts are covered by Medicaid and what other services needed are not covered by Medicaid. This is a philosophical question regarding what is our focus. As a Medicaid organization, clearly the question is how the population accesses services covered by Medicaid.

Mr. Bouman stated that he agrees that the charge should be organization centric. We dealt earlier with a lot of access issues just with eligibility which is the “front door” to access healthcare. Also, there is having adequate providers so that when you have the coverage, you can actually get in to see somebody.

- *Advocacy for services*

Mr. Bouman stated that the subcommittee’s role is to suggest improvements and to help translate what is going on back to the substantial number of groups and people who are watching it and trust it. He noted that if the access issue is that there is not enough money for a service as it is not covered under Medicaid but could be that seems like a legitimate matter. When at some point it is a budget and political decision, this committee could help to work those things up.

Heather O’Donnell added that maybe part of the charge of this committee is to look at some of the ideas that have been discussed and think about 3- 5 years out and what advocacy needs to be done around some of these issues to preserve payment or to Medicaidize some of these services like targeted case management or consider waivers for some other services. Maybe we are more of a strategy committee.

Chairman Pick added that the Access subcommittee is part of the broader Medicaid Advisory Committee (MAC). He would see the MAC as the appropriate venue for the Access committee to refer back those aspects that are not specifically access issues but are issues that affect access. The MAC would decide what the best way to deal with it and decide if it should be advanced legislatively.

- *Provider and member training needs*

Chairman Pick stated that in addition to having new providers you also have a population that has never used an insurance plan and likely is not used to accessing benefits through a payer managed program. They are used to walking into the emergency room. Without educating the newly eligible members in addition to the providers, the same practice patterns will occur until people are reoriented on how to use the insurance.

Chairman Pick summarized that in terms of the scope of the committee’s work, the focus needs to be on Medicaid benefits that will be available to the new Medicaid population and mechanisms that will be developed to train and educate both the provider and the member population to enable them to access those services in an appropriate and timely way when they need them.

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Director Hamos stated that educating new providers is useful but it is about 10 months from now.

- *Reporting Access issues or problems*

Dr. Huggett asked how we report when we see an access issue arise. Is there a hotline or dedicated email spot to report access issues? Can we publicize this as we train new providers? He added that it is also important to look at this for persons enrolled in Medicaid managed care. The Access committee has an important function of giving feedback to the Department and to ensure that members have access to maintain their health.

Jan Grimes noted that the Illinois Home Care and Hospice Council's concern will be in looking at unintended consequences of managed care. We are hearing from other states about delayed authorization that gets in the way of some Medicare rules, too few visits and limited patient choice. If some of those things become problematic that is a way on the ground that we can help the Department.

Chairman Pick advised that he is trying to differentiate between attending a MAC meeting and saying providers are having a problem with access or enrollment or managed care issues, versus an access workgroup that is charged by the advisory committee to complete a specific work product. As a subcommittee, our charge is to have a work product so just providing feedback is not a work product.

- *Learning about access from other providers*

Mathew Collins stated that HealthSpring is having a lot of conversations with providers who aren't currently billing to help them work within the system and continue to provide care to these residents. Conversations that go on with MMAI are ones that could be carried on to gain leverage for the same purpose. He stated that from an access perspective, HealthSpring has a QIC committee that is charged with looking at access. It has defined standards and metrics that hold us accountable for things like appointment availability, wait times and utilization of emergency rooms. If we do not provide access to members and they use the ER as their place of contact, we can predict the outcome as more expensive and less effective. There may be some opportunities for organizations like an HMO association that has been founded to provide input on the Medicare/Medicaid initiatives to say that these are some of the things we look at for access. HealthSpring would be happy to contribute to the discussion.

Ena Pierce, also with HealthSpring added that this is a framework for the conversation that is quantifiable and can be assessed across different organizations or MCOs. We do it across different populations within our networks and can share with you some of the methodological approaches we take. Some of it is secret shopping, some of it is self-reporting and some of it is survey. We gather information from different points and apply it to a standardized framework to assure that we are meeting network adequacy standards and accessibility. It is adequacy and accessibility and you can't have one without the other.

Chairman Pick stated that we can invite the managed care organization as offered to come in and make a presentation on their existing programs with the other populations that would then be applied to the Medicaid population. We could learn from a principle standpoint how they implement the enrollment and care coordination for the Medicaid population.

Director Hamos responded that if company representatives were asked to come in it should be to respond to some very strategic questions.

Kathy Chan stated that a presentation on the Cook County waiver experience would provide some significant lessons as we roll-out coverage for new Medicaid. There are access issues addressed in the Cook County

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waiver like their decision to cover dental up to age 21 and to waive copays. While not an “apples to apples” comparison, it would be a valuable entity to hear from.

Dr. Huggett agreed that it would be very important to hear from Cook County staff to learn about their experience with enrollment efforts, providing benefits and looking at the availability of specialists.

Ms. Israel noted that Heartland Alliance is enrolling in County Care. The more Heartland does the enrollment and works with County Care, the type and nature of the access issues will become clearer.

- *Increasing capacity and access*

Dr. Huggett stated that he is concerned about provider capacity and being able to find specialists like an urologist, gynecologist or optometrist. He believed that a capacity issue exists now with County Care.

Director Hamos stated that mental health is an area where we talk about building up capacity. She asked if the managed care companies are already contracting with individual psychologists as part of our Integrated Care Program. Ms. Pierce stated that HealthSpring was doing this on the Medicare Advantage side. Director Hamos noted that individual psychologists are not able to bill Medicaid directly. She asked if the MCO might also do this under Medicaid.

Ms. Pierce stated that she thought there is an opportunity where some of these traditionally non-Medicaid covered services that are being delivered perhaps through grants or other places are now part of our umbrella of services to be provided. We are trying to work with community behavioral health association or other organizations formerly uncompensated or grant funded for some of these things to strategize and hopefully standardize for the purposes of facilitating the provider community’s ability to navigate eight entities with a simple framework that is at least similar and allows them to bill us, the managed care entity.

Director Hamos talked about a new group of providers, social workers. The state had passed a law that allowed them to bill Medicaid but HFS never opened that up because, in part, the fee-for-service system made it difficult to figure out some utilization controls. HFS talked about it with some kind of MCE in the mix where they would be contracting for some services and working with the provider and the client. This is an example of where some new providers could be brought into Medicaid when managed care is the new structure.

Mr. Bouman stated that this would be very useful to hear about because he believes there are a number of potential opportunities to cover some of the things like case management or even supportive housing if it saves a hospital admission. It might be an attractive thing to have in the mix for a managed care entity.

Mr. Collins shared that he met with the Coalition for Limited English Speaking Elderly (CLESE) to discuss ways to outreach into the community as this population is demographically specific. If we can work together and figure out a way to compensate them, it will yield a better outcome. This is a straight access issue.

HFS Medical Director, Dr. Arvind Goyal noted that CMS has required two years (2013 and 2014) of enhanced payments to primary care physicians (PCPs) and that the committee may wish to discuss how the managed care organizations will deal with it. Will the payment be direct to providers or through the MCO?

Director Hamos stated that HFS needs to talk to PCPs about that and make sure they understand that it is only for two years. She didn’t think the state is in the position to continue that program as it is very expensive. She

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wondered if this would create a new set of expectations for physicians and would they drop out after the two years. She noted that the money hasn't even begun rolling as yet.

Chairman Pick stated that from his experience the PCPs would not likely enroll patients that they would eventually be forced economically to abandon.

Mr. Bouman responded that it wasn't necessary to assume that most new providers would drop out after two years. As we approach the end of the two years it will be important to have information on the impact on things like access and whether this phenomenon was true or not.

Director Hamos stated that she would like to figure out how we measure that at the front end before the first check goes out. How are we going to measure if the higher payment increased access?

- *Enrollment and Care Coordination as an Access issue*

Director Hamos noted that enrollment is an access issue. Just getting people to sign up can be seen as a hassle with a lot of paper work. It may be an issue with the health benefits exchange and certainly will be an issue on the Medicaid side. That is what Cook County Care is already experiencing. How do you develop a really interesting innovative marketing strategy and outreach that works?

Chairman Pick stated that given the evolution of where we're just getting started, enrollment is the first stage.

Mr. Bouman stated that the two things on the table are enrollment and care coordination with its impact on access which we hope is favorable.

Ms. Chan noted that Brian Gorman from the Market Place team is now at the Governor's office. He is the new outreach person and may provide the committee with some useful input. He is participating with the Public Ed subcommittee meetings. He mentioned some RFPs for outreach and enrollment both in terms of a broad enrollment campaign as well as field staff to work with entities facilitating enrollment whether they will be the formally known navigators or enrollment counselors.

Robyn Nardone stated that after Mr. Gorman did his presentation, there was some conversation on what they would be doing next. She is seeing some overlap in the different subcommittee meetings and suggested that there be some coordination. It would be helpful for Mr. Gorman to come to the Access subcommittee so everybody understands what they are kicking off now. Their primary function is enrollment whether for people coming through the Market Place, a.k.a. the Exchange, or folks coming in that way but ending up on Medicaid. It is an overlap.

Secretary Saddler stated that CMMI nationally has grants that they are issuing now for outreach and enrollment. DHS has been asked to write some letters of support for organizations. There are Illinois agencies that are now doing innovations and projects in enrollment and outreach. There may be some best practices that we could gain from those grantees and those efforts going on around the state.

Ms. Chan stated that there is also Connecting Kids to Coverage that is specifically focused on enrolling kids but realizing that ACA is rolling out they have a broader approach as well.

Meeting schedule and Logistics

Chairman Pick and Ms. Moroney would work on putting together some possible dates for the next meeting and will send out information to members to finalize a date. The critical drivers to determine the next meeting

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date are the availability of County Care and HealthSpring. It would be best to plan for the next meeting in April or May. We need to allow some time to let some things happen. Part of our hesitation here is that we haven't had enough time for things to happen.

Ms. Moroney explained that logistics was added to the agenda to make sure the location, phones and video conference was working for people. It seems these are working OK. She advised that the meeting schedule depended on a number of factors but primarily the availability of agency leadership in the room

Chairman Pick added that when there are issues the number of people attending will go up. He also suggested that perhaps the meeting could be scheduled earlier.

7. Information sharing from members

Ms. Chan made the request that when the Maximus data is available one of the pieces that will be helpful is to know how it is broken out when cancellation is based on no response. It would be helpful to know that in terms of the notices.

Chairman Pick echoed her statement and noted that there is a high level of anxiety about individuals being contacted by mail or phone and not having current contact information and individuals being dropped.

Ms. Nardone stated that this issue has come up before and there are certain requirements that we are obligated to track and Maximus is tracking everything they are doing. Any response is going to be documented. It is a matter of running a query to generate the report. It is an important piece if there was no response so they will have to document that. They are required to take extra steps to track people down using resources that aren't necessarily available to the caseworkers to find a better address or phone number.

Chairman Pick responded that information on what efforts were made is something that we would want.

8. Adjournment

The session was adjourned at 1:45 p.m.