

**Illinois Department of Healthcare and Family Services
Public Education Subcommittee
August 13, 2015.
Approved Final Meeting Minutes**

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

Committee Members Present

Kathy Chan, Cook County Health & Hospitals System
Margaret Stapleton, Shriver Center
John Jansa, WKG Advisory (by phone)
Sherie Arriazola, TASC
Erin Weir, Age Options
Nadeen Israel, EverThrive Illinois
Hardy Ware, East Side Health District (by phone)
Brittany Ward, Primo Center for WC
Ramon Gardenhire, AFC
Sue Vega, Alivio Medical Center
Connie Schiele, HSTP (by phone)
Sergio Obregon, CPS

HFS Staff

Lauren Polite
Robert Mendonsa
Bridget Larson
Bridgett Stone
Veronica Archundia

Committee Members Absent**Interested Parties**

Deb Matthews, DSCC
Kelly Carter, IPHCA
Judy Bowlby, Liberty Dental Plan
Jill Hayden, BCBS IL
Paula Dillon, Illinois Hospital Association
Alison Coogan, Legal Assistance Foundation
Kate Shelton, Legal Assistance Foundation
Kathy Waligora, EverThrive Illinois
Hetal Patel, Illinicare Health
Jessie Beebe, AFC
Mackenzie Speer, Shriver Center
Robert Nocon, University of Chicago Department of Medicine
Rachel Sacks, Leading Healthy Futures
Anna Carvalho, LaRabida
Graham Bowman, Chicago Coalition for the Homeless
Enrique Salgado, Harmony
Lynn Seermon, Consultant
Katie Tuten, Catholic Charities
Jennifer Wilbanks, Otsuka
Sheri Cohen, Chicago Department of Public Health
Anita Stewart, BCBSIL
Jim McNamara, V&V Healthcare
Dan Rabbitt, Heartland Alliance
Sandy De Leon, Ounce of Prevention Fund
Luvia Quiñones, ICIRR
Faye Manaster, The Arc of Illinois (by phone)
Mikal L. Sutton, Cigna Health Spring (by phone)
Heather Scalia, Humana (by phone)
Lynne Warszalek, Stickney Health Department (by phone)

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1. Introductions

Kathy Chan, from CCHHS, chaired the meeting. Attendees in Chicago and Springfield introduced themselves.

2. Review of Minutes

Sherie Arriazola made a motion to approve the minutes from the meeting held on June 11th and it was seconded by Nadeen Israel. The minutes were unanimously approved.

3. Care Coordination Update

Robert Mendonsa reported that there are over 2.1 million clients enrolled in care coordination, which is provided by a variety of managed care entities such as MCO, MCCN, ACE, and CCEs. He discussed details of the enrollment process included in a handout that was distributed, which describes the transition plans for ACE and CCE members titled “Medicaid Managed Care Choice Periods and ACE/CCEs Transitions Updates” (Attached.)

Several members of the committee expressed concern that clients may be confused by the terms “Open Enrollment” and “Redetermination.” It was suggested that a clarification note should be added to the open enrollment notice in order to explain that these are two different processes, as well as to emphasize the importance of acting upon each of them. Furthermore, Lauren Polite indicated that the department hopes to decrease this confusion with the enhancements of IES Phase Two, particularly regarding, the “Manage My Case” functionality, through which individuals will have the ability to complete their redetermination online, therefore facilitating the renewal process.

Robert Mendonsa responded to the committee’s inquiries. Faye Manaster stated that there is often a lack of awareness concerning children under the HCBS waivers who are exempt from Medicaid Managed Care. Ms. Manaster noted that, although, the occurrence of these types of complaints is not frequent, she still believes it is important to make the community aware of this policy. Mr. Mendonsa asked for case specific information in order to ensure that policy is applied appropriately.

HFS staff will follow-up with the committee and provide answers to several inquiries:

- Offer a notice regarding provider payments prompted by the budget impasse.
Note: On 7/10/15 HFS issued an informational notice to “All Medical Assistance Providers” regarding the 2016 state fiscal budget:
<http://www.hfs.illinois.gov/assets/071015n.pdf>
- Confirm whether or not, families moving out of a county are subject to a “special enrollment event and whether or not this triggers a new effective date for open enrollment.”
- Make available on the HFS website a list of ACEs and CCEs that have completed their transition to become an MCO, so that advocate groups can be able to assist clients by explaining their options.
- Provide an update concerning the possibility of extending the Medicaid Medicare Alignment Initiative (MMAI) for “dual-eligibles.”

4. ACA Health Care Reform Updates

Application Processing

Lauren Polite reported that the state is keeping pace with application processing. Currently, there are 30,000 pending applications, which include SNAP, TANF, and medical benefits. She noted that, in recent weeks, ABE applications (for medical only) were routed to the Bureau of All Kids. Lauren explained that this practice is periodically followed based upon application volume, staff availability, and workload at HFS and DHS. This means that people will not be able to choose an FCRC at the time

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the application is being submitted; however, once their applications are processed, they will be transferred to the corresponding FCRC where the client reside.

Integrated Eligibility System (IES) Phase Two Update

Lauren Polite indicated that the Department has made a decision to delay the implementation of IES Phase Two. Ms. Polite indicated that the department wants to ensure that everything is working properly before the launching of IES Phase Two. Lauren elaborated that, in the near future, thousands of state employees, contractors, and providers will use IES to view the information they need to administer the medical programs. She said that, when IES Phase Two “goes live,” the legacy system will be “retired.” Consequently, this will involve a huge endeavor that requires adequate coordination of all the different parts of the eligibility system and benefits management.

Kathy Chan asked if there may be any disruptions in terms of processing ABE applications for the Marketplace open enrollment. Lauren stated that processing should not be disrupted. She added that applications are already received into IES without major problems.

5. Illinois Medicaid Redetermination Project (IMRP) Enhanced Eligibility Verification (EEV) Update

John Spears was not available to provide an update about IMRP. Lauren Polite asked the committee to share their thoughts, questions, and concerns, which will be related to Mr. Spears for follow-up. Faye Manaster indicated that there is confusion among the families of a group of children who are enrolled in the Department of Human Services, Division of Developmental Disabilities (DHS/DDD) waivers, regarding parents not being required to provide income information when completing the redetermination process. She added that her organization, The Arc of Illinois, is working in coordination with FHS staff members on the development of a “fact-sheet” intended to clarify this and other significant issues. Kathy Chan emphasized the importance of sharing this resource with advocacy groups and community partners at large and suggested collaborating with Kathy Waligora from EverThrive Illinois.

Sherie Arriazola asked for advice about how to proactively proceed concerning clients who have redetermination dates that are overdue. In addition, she inquired about the appropriate representative authorization form to be used when advocating for clients when contacting the state to discuss a case. HFS staff will follow-up on both requests.

Margaret Stapleton asked for the redetermination statistics. Lauren Polite advised that the quarterly report is published in the HFS website: <http://www2.illinois.gov/hfs/SiteCollectionDocuments/IMRPQtrlyReport22015.pdf>

6. Open Discussion and Announcements

Kathy Chan reported that the state has passed SB 1847, a bill that increases access to SNAP benefits by raising the gross income limit from 130% to 165% of the federal poverty line, or from \$25,737 to 32,653 for a family of 3.

<http://www.ilga.gov/legislation/BillStatus.asp?DocNum=1847&GAID=13&DocTypeID=SB&SessionID=88&GA=99>

Nadeen Israel reported that the state has passed:

SB 2812, a bill which ensures that Medicaid Managed Care Entities (MCEs) do not need to send an Explanation of Benefits (EOB) for sensitive services (e.g. mental services, substance abuse treatment services) in order to protect their members’ confidentiality and reduce barriers to accessing care.

<http://www.ilga.gov/legislation/BillStatus.asp?DocNum=2812&GAID=13&DocTypeID=HB&SessionID=88&GA=99>

HB 2731 is a bill that strengthens transparency in the Medicaid Managed Care System

<http://www.ilga.gov/legislation/BillStatus.asp?DocNum=2731&GAID=13&DocTypeID=HB&SessionID=88&GA=99>

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SB 1410 is a bill that allows parents and legal guardians of school age children to object to health, dental, or eye examinations or immunizations on religious grounds. They must sign and present a form to the appropriate school authority detailing the grounds for their objection:

<http://www.ilga.gov/legislation/BillStatus.asp?DocNum=1410&GAID=13&DocTypeID=SB&SessionID=88&GA=99>

Graham Bowman commented that homeless families who are Medicaid recipients are being denied pharmacy services because of their inability to make co-payments. In Mr. Bowman's opinion, this is prevalent in communities where most of the population is comprised of Medicaid recipients.

Note: On 3/29/2013, HFS issued an Informational Notice regarding the collection of co-payments, among other issues. The notice was mailed to physicians, chiropractors, podiatrist, optometrists, advance practice nurses, Federally Qualified Health Center (FQHC), Rural Health Clinics (RHC), hospital, and pharmacies.

<http://www.hfs.illinois.gov/html/032913n.html>

Kathy Chan asked committee members to contact HFS staff to recommend any new agenda items, meanwhile, it was agreed that an update on current agenda items should be provided during the next meeting.

11. Adjourn

The meeting was adjourned at 12:01 p.m. The next meeting is scheduled for October 8, 2015, between 10:00 a.m. and 12:00 p.m.

Attachment I

MEDICAID MANAGED CARE CHOICE PERIODS AND ACE/CCE TRANSITIONS UPDATES July 2015

Initial Enrollment and Open Enrollment

- Anytime a member is enrolled with a health plan in a managed care program, either through choice or auto-assignment, they have 90 days from that plan enrollment effective date to change plans. An individual is limited to one (1) plan change during their 90-day switch period.
- Clients will also have a 60-day Open Enrollment (OE) period at the end of their 12 month lock-in period. During this 60-day period, a client may elect to switch health plans. Because HFS rolled out the mandatory managed care program in multiple stages over the course of about nine (9) months, Medicaid clients are in their 60-day Open Enrollment periods at different times throughout the year. (see [the initial mailing schedule](#) on the HFS website under Care Coordination).
- Client Enrollment Services sends the OE notices to individuals between 70 and 75 days before the end of their 12 month lock in order to get the notice in the clients hand prior to the 60-day switch period. Once a client has received their Open Enrollment notice, if the client calls Client Enrollment Services to change plans before the 60-day Open Enrollment period, the CEB will take the request and pend it until it can be submitted to HFS and processed.
- Attached is a sample of an Open Enrollment letter. The OE letter includes the list of all of the plan options for the client that are available in their area of service at that point in time. A client must contact Client Enrollment Services via the Call Center or via the Program web site to receive more information about their plan choices and assistance in switching plans, if needed.
- If clients do not actively change plans during their Open Enrollment period, they will remain in their current plan for another 12 month lock-in period. A client is not required to switch plans during their Open Enrollment Period and is not assigned away from their plan if there is no active plan switch.
- HFS averaged about 20,000 health plan “switches” per month in April – June but expects fewer switches moving forward as the volume of clients in their 90-day switch periods will decrease with the completion of expansion.
- If someone chooses to switch plans after having been auto-assigned, HFS considers that plan switch to be an active enrollment choice made by the individual.

ACE and CCE Member Transitions

ACEs and CCEs were given the option to either become a MCCN or to establish a relationship (contractual or otherwise) with an existing MCO or MCCN to assume the ACE or CCE members. **The primary goals of these relationships/transitions are to minimize disruption to the members and maintain the care coordination models in which the state and plans have invested.** With that in mind:

Update on Open Enrollment and ACE/CCE Transition (July 29, 2015)

Attachment I

- ✓ HFS' expectation is that for health plans that establish a relationship with an existing MCO, the MCOs are tasked with working with the ACE or CCE to get all of the plan's PCPs and critical specialists into the MCO network. The Department will be monitoring this closely throughout the transition process.
- ✓ Members enrolled in an ACE or CCE that establishes a relationship with an existing MCO, will be transitioned to the partner MCO; however the client will be provided with a 90-day switch period from the effective date of transition to change health plans. . The individual must contact Client Enrollment Services via the Call Center or the online enrollment portal to request a change in health plans during their 90-day switch period. If the client switches health plans during their 90-day switch period, the client's anniversary date will be the first date of enrollment in the new health plan.
- ✓ Starting 2 months or sooner, prior to the effective date of the transition of ACE or CCE members to the partner MCO, the following may occur:
 - HFS will gradually remove the ACE or CCE from the client enrollment materials/website and educate the call center workers. HFS may also decide to suspend future auto-assignment and voluntary choice to the ACE or CCE health plan.
 - The partner MCO and the ACE or CCE work together to enroll PCPs that are active in the ACE or CCE network, but not in the MCO network.
 - The clients will receive written notice explaining the transition, and the option to switch health plans during the 90-day switch period.
 - The MCO sends the clients member materials and member ID cards.
 - The MCO and ACE or CCE may have a readiness review.
 - HFS transitions the members in its system from the ACE or CCE over to the MCO.
- ✓ HFS expects most if not all ACEs and CCEs to move to risk or partner with an MCO. If that is not the case, HFS will look at options for the members based on the individual ACE or CCE.

To date, three CCE plans have completed a transition to a partner health plan. Effective July 1, 2015, members enrolled in the EntireCare CCE health plan were transitioned to NextLevel CCE for care coordination and members enrolled in My Health Care Coordination CCE were transitioned to Health Alliance. Effective August 1, 2015, members enrolled in La Rabida's CCE were transitioned to CountyCare MCCN.

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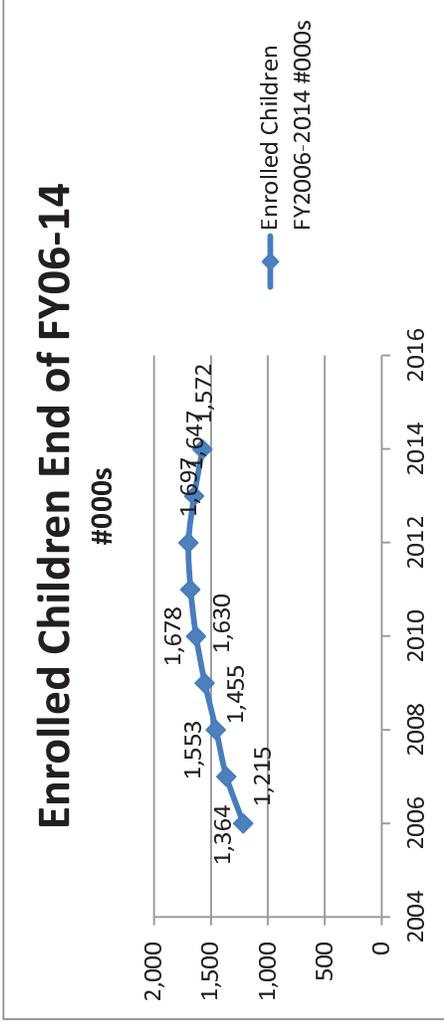
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Children's Enrollment

End of FY	Enrolled Children #000s
2006	1,215
2007	1,364
2008	1,455
2009	1,553
2010	1,630
2011	1,678
2012	1,697
2013	1,647
2014	1,572



Enrolled Children End of FY06-14 #000s

Enrolled Children
FY2006-2014 #000s

End of Month 2012	Enrolled Children #000s	End of Month 2013	Enrolled Children #000s	End of Month 2014	Enrolled Children #000s	End of Month 2015	Enrolled Children #000s
Jan	1,696	Jan	1,666	Jan	1,582	Jan	1,540
Feb	1,699	Feb	1,665	Feb	1,582	Feb	1,540
Mar	1,701	Mar	1,667	Mar	1,591	Mar	1,531
Apr	1,701	Apr	1,665	Apr	1,595		
May	1,698	May	1,656	May	1,587		
June	1,697	June	1,647	June	1,572		
July	1,694	July	1,638	July	1,564		
Aug	1,694	Aug	1,635	Aug	1,567		
Sep	1,689	Sept	1,626	Sept	1,561		
Oct	1,681	Oct	1,610	Oct	1,554		
Nov	1,674	Nov	1,600	Nov	1,547		
Dec	1,668	Dec	1,587	Dec	1,541		

