

Illinois Department of Healthcare and Family Services
Access Subcommittee informational session*
October 24, 2012

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

Members Present

Malba Allen, Consultant
John Bouman, The Shriver Center
Kathy Chan, IMCHC
Andrea Cooke, LCSW, Student
Linda Diamond-Shapiro, Access
Mary Driscoll, IDPH
Susan Hayes Gordon, Lurie Children's Hospital
Melissa Gutierrez, SUHI
Thomas Huggett, M.D. Circle Family Healthcare
Nadeen Israel, Heartland Alliance
Judy King, M.D., Consumer Advocate
Margaret Kirkegaard, M.D. IHC, AHS
Hong Liu, Midwest Asian Health Association
Malik Nevels, IAACP
Heather O'Donnell, Thresholds
Randy Sadler, Youth 1st Counseling
Zakiya Moton, U of C Med Center via telephone

HFS Staff

Julie Hamos
Sharron Mathews
Arvind Goyal
Theresa Eagleson
James Parker
Mike Koetting
Robyn Nardone
Debra Clemons
Selma D'Souza
Gabriela Moroney
Andrea Bennett
James Monk

DHS executive staff

Michelle Saddler, Secretary
Dr. Lorrie Jones, Director, DMH
Theodora Binion, Director, DASA
Patricia Reedy, Director of Social Work, DMH

Members Absent

Eli Pick, Post Acute Innovations
Jan Grimes, IHHC
Luvia Quinones, ICIRR

Interested Parties Continued

Stephanie Altman, HDA
Maryellen Baker, MedImmune
Steve Bradley, UIC – DSCC
Josh Collins, Citizen Action-IL
Matt Collins, HealthSpring
Mike Colif, ICARE, Wisconsin
Mike Cotton, Meridian
Deila Davis, Access
Andrew Fairgrieve, HMA
Gary Fitzgerald, Harmony -Wellcare
Denise Gaines, SEIU
Ramon Gardinhire, AIDS Foundation of Chicago
Jill Hayden, IPHCA
George Hovanec, Consultant
Ollie Idowu, IPHCA
Nicole Kazee, U of I Health System
Kiernan Keating, Takeda
Marissa Kirby, IARF
Bill Kolen, LAF
Vighny Kotle, Meridan
Marvin Lindsey, CBHA of IL
Kevin McFadden, Astra Zeneca
Jen McGowan, Governor's office
Diane Montañez, Alivio Med Center
Pam Rodriguez, TASC
Amy Sagen, UIC Health Center
Donna Scherer, DSCC
Ben Schoen, Meridian
Joe Summers, Novo Nordisk
Erin Vaughan, Astra Zeneca
Matt Werner, Consultant
Erin Weir, Age Options
Stacey Whipple, Meridian

***Due to the late posting of the agenda, this is not an official Access subcommittee meeting.**

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1. Call to Order

The meeting was called to order at 10:35 a.m.

2. Introductions

Participants and HFS staff in Chicago and Springfield introduced themselves.

Ms. Susan Hayes Gordon introduced herself as the chairperson of the Medicaid Advisory Committee (MAC) but not the new Access subcommittee. She announced that she would be the acting chair for today's meeting and that the names of the Access committee members had been posted online.

<http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommisions/MAC/access/Pages/members.aspx>

Director Hamos announced that the Department posted the meeting agenda on October 23rd, which did not meet the Open Meetings Act requirement to post 48 hours in advance. Therefore, the meeting is not a formal subcommittee meeting. She does not anticipate a reason for the new Access subcommittee to take any formal actions today. The Department's intention was to go ahead with today's presentation as it is important and would likely be repeated. Persons were welcome to stay or leave. The first formal Access subcommittee meeting would be rescheduled with a proper posting.

Dr. Judy King stated that the meeting was not a legal meeting and that she felt disrespected with how the Department has treated her from the conception of the Access subcommittee through today's meeting, including a lack of response to her questions regarding participation in the subcommittee. Because the meeting is not legal, she would not stay.

Chairperson Gordon acknowledged that Dr. King had done a great job in bringing some outstanding members to this committee and thanked her. She also thanked HFS staff for developing the potential member survey. The process gave the subcommittee a good cross-section of smart and committed people.

Review of the amended MAC Bylaws and Access Subcommittee charge

Chairperson Gordon stated that the MAC had recently added a vision statement to Section 1 of the MAC bylaws which reads as follows: "It is the vision of the MAC to ensure that populations covered under HFS' Medical Assistance programs have timely access to quality care that meets their need regardless of race/ethnicity, primary language, geography or age."

She also reviewed the Access subcommittee charge that appears on the HFS website.

<http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommisions/MAC/access/Pages/default.aspx>

3. Director's Report

Director Hamos advised that she would not take much time so the committee could get to the discussion of the expansion of Medicaid under the Affordable Care Act (ACA). Access is an important issue for those new enrollees expected to come into the program. The department wanted to do this briefing before the election and also understands that the election will affect the direction of expansion efforts.

Director Hamos announced that HFS has made the first round of awards for our Innovations project. This project will help redesign the Medicaid service delivery system especially for seniors and people with disabilities who have the most complex health and behavioral health needs. The six awardees all offer some interesting innovations in the area of service delivery. Awardees are all provider-organized networks of care and organized at the grassroots level to provide care coordination. There will be an opportunity to meet and hear from them and, also to have input on how they plan to roll this out.

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Within the next week, HFS is expecting to announce the awardees for the duals project called the Medicare Medicaid Alignment Initiative. HFS is working with the federal government and anticipates Illinois will be one of the states selected. HFS plans to announce how we will roll out that dual eligibles project.

Sharron Mathews, HFS Assistant Director, introduced Michelle Saddler, Illinois Department of Human Services (IDHS) and executive staff, Dr. Lorrie Jones, Director, DMH, Theodora Binion, Director, DASA and Patricia Reedy, Director of Social Work, DMH. Secretary Saddler shared that IDHS is a sister agency to HFS and is considered the subject matter expert in the Single Mental Health Authority and Substance Abuse Authority. She stated that implementation of Managed Care was very important to DHS to ensure that access to health care is really available.

4. Future meeting dates

Future meeting dates could not be set as this was not an official Access subcommittee meeting. Later in the meeting there was some discussion about a potential subcommittee meeting date in late November.

5. Presentation of Benchmark Medicaid Plan

Chairperson Gordon introduced HFS staff, Gabriela Moroney with the Office of the Director and Mike Koetting, Deputy Director for Planning and Health Reform Implementation.

Ms. Moroney reviewed the handout, "Introduction to Benchmark Medicaid" posted online at: http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommissions/MAC/News/Pages/102412_macaccess.aspx.

She stated that the Affordable Care Act (ACA) establishes a new, mandatory Medicaid eligibility group of non-pregnant adults aged 19-64 with incomes $\leq 133\%$ FPL and that states must provide at a minimum Benchmark coverage to this group. The benchmark Medicaid requirements and the Exchange benchmark (which establishes minimum essential coverage for individual and small group plans to be sold on the Health Benefits Exchange) both must cover the same ten categories of essential health benefits; further alignment, while possible, is not required.

In addition to the ten categories of essential health benefits, benchmark Medicaid is also required to cover EPSDT services for persons under 21, services provided by federally qualified health centers and rural health centers, non-emergency transportation and family planning services and supplies.

She noted that Illinois must specify its Benchmark benefits and EHB reference plan as part of 2014-related Medicaid State Plan changes and must also provide public notice and opportunity to comment before submitting Benchmark plans to the federal CMS.

Director Hamos added that the state anticipates about 500,000 more Medicaid enrollees over the next 3 to 4 years. About two-thirds would be new Medicaid or newly eligible enrollees and about one-third are persons that would be eligible today under current rules. This second group is sometime referred to as the "woodwork effect" group that would sign up as they realize others are applying for state health insurance. HFS would initially receive 100% federal match (FMAP) for the new Medicaid group; the match eventually ratchets down to 90% in 2020 and beyond. The FMAP for the second "woodwork effect" group would be 50%. Of the estimated 500,000 persons to be added, the Cook County waiver program may enroll about 120,000 persons that would be part of the new Medicaid group.

Mr. Koetting stated that he would outline a broad way of looking at options in designing a Benchmark Medicaid plan and then would like to get a sense of what this group and other people think about those

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broad approaches. He added that HFS is awaiting guidance from federal CMS, as HFS will need to obtain federal approval.

He noted that an important distinction between new and old Medicaid is that if an applicant meets the Department's definition of disabled, the approval would automatically and always be old or standard Medicaid. This is an important distinction because a lot of the discussion is around that group that tends toward the category of persons with disabilities. He referred to the Options in Designing Benchmark Medicaid section of the "Introduction to Benchmark Medicaid" handout which identifies three options.

- Option #1 has full alignment between Benchmark Medicaid and Standard Medicaid including coverage of Long-Term Supports and Services (LTSS).

This is the easiest thing to do from an administrative standpoint. The state may claim some enhanced FMAP and may include services not typically found under a commercial insurance plan for persons not actually classified as disabled. Because there is no asset test for new eligibles, a person with low income but significant assets could receive expensive services at taxpayers' expense.

- Option #2 has a partial alignment between Benchmark Medicaid and Standard Medicaid covering the same medical and behavioral health services but no LTSS component.

This is much more like conventional health insurance. This option may create an incentive for clients in need of some LTSS to have to qualify as seniors or persons with disabilities (SPDs), at which point Illinois cannot receive enhanced FMAP for those services and would be responsible at 50/50 FMAP.

- Option #3 has a partial alignment between Benchmark Medicaid and Standard Medicaid covering the same medical and behavioral health services as well as "LTSS light", a package of home and community based services targeted to the needs of new eligibles.

This could include certain services not typically found in commercial health insurance plans but included among Medicaid's long term supportive services. HFS would be able to use those added services as a way of keeping people out of institutional care. It addresses the fact that low income people who do not have access to health insurance have a different set of needs than those covered by commercial insurance. This option allows the state to claim enhanced FMAP. While a person with significant financial resources could receive services at taxpayers' expense, it would not be as expensive as the full LTSS services under option #1.

Mr. Koetting stated that the department is looking for information about how large some of these cost swings might be or other information about what services for the newly eligible population. The floor was opened for comment.

Director Hamos stated that HFS doesn't have the specific numbers on uninsured persons in Illinois. The Department looks to persons at the meeting to identify people they serve and describe the services they need.

She stated that regarding option #2, an important part of the deliberation is thinking about people with countable income over the 133% of poverty and up to 200% of poverty. They won't qualify for Medicaid but could qualify for commercial health insurance on the open Exchange and with tax credits to help pay for premiums. There is concern about people going back and forth between coverage on the exchange and

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Medicaid coverage, often referred to as “churn”. HFS wants to ensure that these individuals have continuity of care to improve health outcomes.

Director Hamos stated that HFS is also very concerned about having provider capacity for 500,000 new Medicaid enrollees. Not creating a disincentive for persons to move into the private insurance market can be a good thing as they may have access to new and different providers. This is another point to consider for Option #2.

Director Hamos stated that when we think about an ex-offender single male, coming out of Cook County jail, some qualify as SPD and some do not. Some may be potentially eligible but not qualify because of the difficulty of the process. The question we ask is what services do they need that are not strictly in the medical package but could be helpful to maintain a high quality of life and promote their well-being. What are the long-term supports and services that they need to succeed?

Mr. Bouman responded that persons determined not disabled have two ways to go. One is waiting until they meet the definition of disabled and eligible for Medicaid with a 50% FMAP. Another way to go is to provide appropriate supports and move the individual toward recovery using new Medicaid with essentially 90% FMAP and not have the person end up on the old Medicaid. For example, assist the ex-offender that has needs like mental health or behavioral health services or dental services to become employable.

Dr. Thomas Huggett commented that his agency works with 22 homeless shelters on Chicago’s Westside with clients in the same situation we are discussing. His staff talks about “everything from the neck up” meaning mental and behavioral health, dental care and eye care services. Circle Family works with Illinois Eye Care for glasses through their Vision for Hope program.

He stated a barrier to care is the cost of anti-psychotic drugs. It takes a long time to get Medicaid and the agency struggles with the cost of drugs in the interim. Several patients have been in and out of hospitals or prisons because they did not have their medication. He would like to see a quicker turnaround in getting people enrolled in Medicaid to get stabilizing medications.

Dr. Huggett added that a problem that providers have in accepting Medicaid is that payment is so delayed, especially to health centers that serve folks with these needs. Some of his staff are not getting paid for weeks at a time. This is a problem.

Dr. Huggett stated another barrier to care is the 4 prescription limit and additional paperwork that must be done to authorize additional prescriptions. The extra half-hour needed to complete paperwork is time that would be better spent on providing care.

Director Hamos stated that the essential standard Medicaid medical and behavioral health service package includes prescription drugs, mental health and behavioral health services. She asked what other kind of supports clients need if they are not fully disabled. Are the service shown in the table of waiver services important to this population?

Malba Allen asked if there is any onus on the patients to maintain certain measures of wellness or is the onus all on the provider to make sure the patient becomes healthy? The health issues may be that the patient is diabetic or has hypertension or is smoking.

Director Hamos stated that the department doesn’t have anything like that in place now but she likes the idea. The Department is open to suggestion for developing patient incentives.

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Mary Driscoll advised that public health data indicates that a lot of persons with Medicaid coverage are showing up in the emergency room with conditions that would be better treated through primary care. She stated that access is more than saying we have enough primary care doctors. It also includes the type of services that Dr Huggett mentioned and requires looking at the availability of providers in other than regular weekday work hours. Are providers culturally competent and do they understand the community? These issues should be considered elements of access.

Linda Diamond-Shapiro stated that Medicaid patients assigned somewhere else come to Access sites because their medical home site is closed. Services may be provided but payment is denied. Access is looking at expanding hours perhaps to Sunday thinking that it may be better to bring a child in on a Sunday afternoon rather than missing work on Monday. Extended hours are something to offer in communities with "pre-SPD" persons.

Mr. Bouman stated that persons recovering from an accident or mental breakdown or whatever they were hospitalized for could benefit from waiver services that help to prevent readmissions or sinking into a disabled category. He described a relative that was recovering from knee surgery that needed several months of rehab in the home. Without those services, he may have needed to be readmitted to the hospital.

Ms. Driscoll added that the waiver services could benefit persons with chronic illnesses like Crohn's disease or diabetes which are best managed in a primary care setting and very costly if not.

Melissa Gutierrez shared that Sinai Institute provides care around a community health worker model. There is research that shows when you provide case management it is possible to save \$7 on \$1 of intervention. She stated that looking at how services are delivered is important. For example Circle Family Healthcare is not getting paid for some services but if patients are enrolled in a different healthcare delivery system we may be ahead of the curve in providing more cost effective services.

Patricia Reedy commented that people coming out of jail who may not have met the state's definition of disabled may still have serious health problems often of a behavioral health nature and need additional support services. Even though behavioral health is included in the standard Medicaid medical and behavioral health service package, the services one receives with a regular Medicaid card may not be sufficient. For example people with serious addictive illness, bipolar disorder or personality disorder need a lot more support. HFS should look at program services used with ex-offenders like "community support". The program is similar to case management but puts more responsibility on the individual. HFS may also want to add Individual and Placement Support (IPS) services, an evidence-based way to help persons with mental health problems to get and keep employment. Evidence-based support services should be included in whatever of the three options is selected.

Nadeen Israel echoed Mr. Bouman's point about providing supportive services with the example of a relative that had a stroke but couldn't receive needed physical therapy and rehab services. The relative entered a nursing home and eventually qualified for Medicaid and Medicare. She died there 7 years later with a horrible deterioration of health that could have been avoided if she had the rehab needed immediately following the stroke. The relative had started with a chronic health condition but couldn't qualify initially as disabled. Ms. Israel asked if HFS would look at adding services for this new Medicaid population like case management support for housing to keep persons healthy in the community. There is a report put out by Heartland Alliance, CHA and HDA that outlines services that could be Medicaid billable but aren't now.

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Mr. Koetting stated that he had a strong assumption that the federal government would not approve a richer expansion population at a higher match for other than base Medicaid.

Theresa Eagleson stated that HFS currently pays for case management services in many circumstances. HFS has targeted services for specific populations and specific needs including mental health for targeted case management. HFS needs to look at how we incorporate that for specific populations and specific situations and also for the Care Coordination Entities (CCEs) and under Integrated Care initiatives. Care coordination fees may be used to pay for case management services that are less medical and more social services to support individuals in the community in a healthier environment. There are ways that HFS is doing that in Medicaid now as well as taking advantage of federal funding for this in the future.

Marissa Kirby asked how comments may be submitted regarding LTSS services to be included in the Benchmark Medicaid. She asked if it is correct that the Medicaid benchmark plan will include prescriptions but be subject to the 4 prescription limit.

Director Hamos answered that we need to have an official comment approach and that the department would get that out to meeting participants. She explained that the legislature would need to authorize the expansion of Medicaid to new people and will ask about the benefit package. The 4 prescription limit was put in place with approval of the SMART act and it would seem likely to be included in the expansion. The legislature never said that there was a hard limit of 4 but there is a prior approval process for prescriptions over 4. Because of the volume of cases, it has become an issue that we are again looking at.

Jill Hayden asked if there are services within DHS or other agencies that the state is paying 100% costs that will now be covered under the new Medicaid expansion so that there will be some cost savings?

Mr. Koetting advised that there will be some savings but that the department didn't believe the amount would be enormous as the tendency over the last several years is to drive these services to Medicaid.

Secretary Saddler affirmed that there are still people for whom we provide general revenue fund (GRF) supported services who don't qualify for Medicaid today. She added that so much of what people are touching on has to do with prevention services, some of which have not been Medicaid reimbursable. We have talked about how care coordination fees could be used toward things like case management and other prevention services. Managed care reform and Medicaid reform are linked because many of our clients need coordinated care. Director Hamos has talked about positive health outcomes needing to be in the incentives of managed care reform. DHS is interested in making sure that prevention in some form or fashion is provided. Prevention services are the most vulnerable services around. Because they're not currently reimbursable they're some of the first cut which then result in some of the most costly services.

Secretary Saddler stated that as HFS puts together a forum or vehicle for input about access, it is important to point out that access is different from the product and the package that everyone is making decisions about. Product is not everything. The department needs to figure out how persons coming out of prison may have someone there to get them enrolled or eligible for healthcare services. The state doesn't really have the resources to do this. She is interested in comments on access not just products to be offered.

Ms. Allen asked if any thought been given to telemedicine for the new population. Mr. Koetting advised that in many cases telemedicine is allowable under Medicaid. It is a question of how it is used. It gets back to the comments some have made that it is not just what you list on a piece of paper but how you present the services and how you make them available to people.

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Director Hamos added that like Electronic Health Records (EHR) with telemedicine we are in the early stages of thinking about and using technology via our service delivery. She stated that she sees increasing interest. An issue with telemedicine is finding willing partners at both ends of the video. Those partnerships are a challenge right now but she believes greater use of telemarketing is coming.

Mr. Bouman commented that it might be worth considering a plan amendment for some of the preventive type services because of the long term impact on health outcome and to avoid unnecessary hospitalizations. HFS could cover some of the things that Secretary Saddler referred to and Ms. Israel mentioned like case management in supportive housing.

Mr. Koetting responded that some of those may not be Medicaid services without a broader 1115 waiver.

Director Hamos restated that the feedback that HFS is looking for is comments on what people need and how they can benefit. She advised that HFS would create a mechanism to provide this feedback.

Mr. Koetting stated that the department will need to get out information on how persons can provide comments and get that out quickly.

Chairperson Gordon asked if the Director could identify a date by which HFS wants this feedback.

Diane Montañez asked if the expansion group would be exempt from participating in managed care. If not, many of these preventive questions will be resolved as a part of the process. If these people are in managed care in 2015, the preventive pieces of managed care like case management are included.

Mr. Koetting responded that it is the department's assumption that we would have to get there. It is our expectation that anyone that comes into the expansion population would be enrolled into some form of coordinated care as of 2014 when the expansion coverage starts.

Andrea Cooke stated that consumers should be responsible for their health. However people with low income are not fully able to engage in health promotion. People need nutritious food and exercise that is not available to people with low income. She suggested that an expansion of the money available on the LINK card would provide more nutritious food and more exercise programs that people could engage in. She added that mental health consumers are very sedentary and the medications people take lead to conditions like diabetes and metabolic syndrome.

Ms. Mathews stated that most of who are around the table have been collectively serving women, children and seniors. The new population will include a significant percentage of males that are young and middle aged, coming from different backgrounds and being of color. This is a different client for most providers with perhaps the exceptions of prisons and IDOC. HFS is learning more from DASA with individuals that are going to a lot of the hospitals for inpatient detoxification and are predominately male and of color. This means a different mindset in terms of case management services and life planning processes.

Ms. Gutierrez commented that these persons are not likely to sign up for Medicaid or go see a physician. She stated that there are alternative models for how we engage these individuals to access services before they are back in jail or in the emergency department or have a permanent disability. Home and Community based services are a vital component to these difficult to reach populations.

Ms. O'Donnell commented about access and persons coming out of jail. She advised that there is a group of substance abuse and mental health providers that is being convened by an organization called TASC

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(Treatment Alternatives for Safe Communities). The county justice system is heavily involved in looking at how to connect this population to health care services. She hopes to share some of the ideas that come out that workgroup. Secretary Saddler's point that providers need to be at the jail or other discharging facilities is critical.

Ms. Mathews advised that HFS supports TASC and has worked with the Governor's office and sister agencies for over a year at issues of access for people who are involved with the criminal justice system. She doesn't want the group to get caught up in stereotypes of the male population of color. The new Medicaid group includes persons who are young and getting the opportunity to apply for health insurance for the first time. It includes those who have been working but have now come on hard times because of the recession. They have different expectations about customer service than what we are currently providing. We will have a wide spectrum of male individuals coming from urban settings and throughout the state. It is important that we pay as much attention to those that are institutionalized coming out to community as well as those that are part of community.

Mr. Bouman suggested that we look at services for applicants going through a disability determination by the Client Assessment Unit (CAU), that also file for Supplemental Security Income, (SSI) and are then denied. Persons with acute or chronic conditions that are unable to work but not disabled enough for SSI or above the asset disregard are part of the groups we are after here.

Ms. Reedy stated that in considering a state plan amendment (SPA), maybe a good place to start is Medicaid rule 132 and for DASA services, Medicaid rule 2060/2090.

Hong Liu, with the Midwest Asian Health Association (MAHA) stated that her community needs a good patient navigation system to help people access the Federally Qualified Health Centers (FQHCs), Cook County hospital and other public health systems offering early intervention services. The system should offer culturally competent and language appropriate community outreach to encourage at-risk families to access early intervention services. Such services can help reduce the high cost of hospital and ER care.

MAHA is located in the south China-town community with clients receiving 100% public health and prevention health services. The community includes immigrants with no insurance and no access to healthcare. Ms. Lui stated that MAHA offers a monthly comprehensive primary care screening program for diabetes, hypertension and hepatitis B. About 20% of the population is infected with the hepatitis B virus that can lead to liver cancer and cirrhosis. About 50% of the people screened have high cholesterol, hypertension and high blood sugar that can lead to heart disease. Without health insurance or early intervention services, patients eventually end up in the emergency room or are hospitalized.

6. Open to Committee

Chairperson Gordon asked what issues members want to include on agendas for future meetings.

Dr. Kirkegaard had a few suggestions and some things she wanted to clarify. She asked if there is a process to submit an agenda item for the subcommittee. She would like the department to provide the rules and requirements for the Open Meetings Act. It behooves the committee to understand what the responsibilities are as representatives of the public on this committee. (The Illinois Attorney General's online training on the Open Meetings Act [<http://foia.ilattorneygeneral.net/Training.aspx>] and frequently asked questions document [http://foia.ilattorneygeneral.net/pdf/FAQ_OMA_Government.pdf] provide helpful information on this topic.)

Dr. Kirkegaard suggested the committee look at a summary of federal requirements regarding issues of health disparities or reporting on racial/ethnic disparities and requirements for the states to establish a

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minimum baseline for how to move forward.

Dr. Kirkegaard suggested that if there are activities going on in other states in their Medicaid programs in regards to health disparities, what are those? This doesn't need to be a comprehensive analysis but a look at how other states address disparities. Is it through public committees or a taskforce or through agencies?

Ms. Mathews stated that there are two entities she is aware of working on healthcare disparities that HFS works with. There is a disparities commission that just started with state representative, Monique Davis and state senator, Mattie Hunter as the chairs. The "Commission to End the Disparities Facing the African-American Community" has held one meeting so far and plans to hold meetings across the state. HFS is sitting on this legislative commission. The commission will look disparities in a broad range of areas from education to housing and includes healthcare and health services. There is also a healthcare disparities committee in the house chaired by state representative Will Davis that has gone on for a couple of sessions and targets health disparities.

Ms. Gutierrez stated it would be important to look at what data the subcommittee would need and how to best collect it. She noted that earlier a consultant's report with data on the uninsured target population was referenced. She wanted to know if this could be shared. Director Hamos advised that the report is available on line from the healthcare reform implementation council at healthcarereform.illinois.gov (http://insurance.illinois.gov/hiric/resources/ILBackgrounResearchFinalReport_September2011.pdf). She also referred to the population data that was included in the handouts. Ms. Kathy Chan raised a question related to access issues. She noted that the ACA provides for 100% federal match for increasing Medicaid reimbursement rates up to the Medicare rates for primary care providers in 2013 and 2014. She was curious if HFS is doing that and will be ready to do that on January 1, 2013.

Director Hamos stated that it's on the department's radar. She would check into the mechanics of that.

Chairperson Gordon summarized that the department will be in touch with the committee members about the next meeting date and issue an agenda in advance. HFS staff will include information on the Open Meetings Act.

7. Adjournment

The session was adjourned at 12:00 p.m.