

Illinois Department of Healthcare and Family Services
Access Subcommittee Meeting
November 19, 2012

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

Members Present

Chairman Eli Pick, Post Acute Innovations
Malba Allen, Consultant
John Bouman, Sargent Shriver National Center on Poverty Law
Kathy Waligora for Kathy Chan, IL Maternal Child Health Coalition
Andrea Cooke, LCSW, Student
Deila Davis for Linda Diamond-Shapiro, Access Community Health Network
Mary Driscoll, Illinois Department of Public Health
Susan Hayes Gordon, Lurie Children's Hospital
Melissa Gutierrez, Sinai Urban Health Institute
Thomas Huggett, M.D. Circle Family Healthcare Network
Nadeen Israel, Heartland Alliance for Human Needs and Human Rights
Vernon Johnson for Malik Nevels, IL African American Coalition for Prevention
Debbie Pavick for Heather O'Donnell, Thresholds

Members Absent

Margaret Kirkegaard, M.D. Illinois Health Connect, Automated Health Systems
Jan Grimes, IL Homecare and Hospice Council
Luvia Quinones, IL Coalition for Immigrant and Refugee Rights
Hong Liu, Midwest Asian Health Association
Randy Sadler, Youth 1st Counseling
Zakiya Moton, University of Chicago Medical Center

HFS Staff

Julie Hamos
Sharron Mathews
Arvind Goyal
James Parker
Mike Koetting
Gabriela Moroney
Robyn Nardone
Shannon Stokes
Sally Becherer
Andrea Bennett
James Monk

Interested Parties

Stephanie Altman, HDA
Carrie Chapman, LAF
Josh Collins, Citizen Action-IL
Matt Collins, HealthSpring
Andrew Fairgrieve, HMA
Eric Foster, IADDA
Katie Galle, Meridian Health Plan
Donna Gerber, BCBSIL
Emily Geier, Access
Jill Hayden, IPHCA
Marvin Hazelwood, Consultant
George Hovanec, Consultant
Ollie Idowu, IPHCA
Marissa Kirby, IARF on telephone
Randall Mark, CCHHS
Deb Mathews, UIC – DSCC
John Peller, AIDS FDN of Chicago
Ena Pierce, HealthSpring
Christy Serrano, Ounce of Prevention
Erin Weir, Age Options

Illinois Department of Healthcare and Family Services
Access Subcommittee Meeting
November 19, 2012

1. Call to Order

Chairman Pick called the meeting to order at 11:00 a.m.

2. Introductions

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

3. State of Illinois Ethics Training Information

Shannon Stokes from the HFS Office of General Council reviewed the Ethics Training requirements for committee members and asked that the training be completed by December 14. She stated that members may contact her at shannon.stokes@illinois.gov. She stated that it is acceptable to scan or email the Acknowledgement of Participation statement to her. If a person is on two HFS committees, the form needs to be completed only once.

4. Director's Report

Michael Koetting, Deputy Director for Planning and Health Reform implementation advised that he would forego the report at this time and move to item five.

5. Recap of October 24, 2012 briefing session

Mr. Koetting stated that there was not a formal committee meeting held on 10/24, but a group discussion in which the Department laid out options for the benchmark package for newly eligible Medicaid clients:

1. The standard Medicaid package.
2. The standard Medicaid package minus long term care supports and services (LTSS).
3. Comparable to employer-sponsored health care but with some specific LTSS services to meet the special needs of the population.

Discussion ensued, and the Department noted that it would elicit input on the services to be included in the benchmark health benefits service package.

6. Benchmark Medicaid

Review of input from members and other stakeholders

Gabriela Moroney described the process by which HFS requested and received input. HFS uses a listserv to manage communication to the Medicaid Advisory Committee (MAC) and its subcommittees. The listserv is also open to other interested members of the public desiring information and updates. HFS used the listserv to elicit input on benchmark Medicaid services. Notice of the request for input was circulated on November 1, with a request for responses by November 14. However, HFS continues to receive and welcome input; Ms. Moroney stated that feedback can be submitted online and asked participants to contact her via email at gabriela.moroney@illinois.gov if they encounter difficulty.

HFS' request for input consisted of two questions:

1. HFS asked stakeholders to consider their uninsured clients and the services that they need to improve their health and quality of life. HFS noted in the request that there would be some people with routine medical needs and others with more complex situations.
2. HFS also asked about specific services that respondents thought should be included in the benchmark Medicaid package. HFS is especially interested in learning if certain long term support and services such as those included in our current waiver programs would be needed by the expansion population. This is with the caveat that HFS is awaiting information from the federal government about what may be included. So the Department elicited input with the understanding that in some ways our options may be limited.

As of close of business on the 14th, HFS had received responses from 34 organizations. Mental health and substance abuse providers were the largest group of respondents. HFS also heard from community health centers, social service agencies, advocacy organizations, some trade and professional associations and a durable medical equipment company.

Initial review of the responses uncovered a few key themes. Ms. Moroney organized them into three categories. The first were some overarching concerns. Respondents saw the survey as an opportunity to weigh in on specific services needed and also to share their thoughts on ways in which the Medicaid system can be strengthened to ensure timely access to appropriate care. She noted that most of those concerns were administrative rather than coverage related but provided

Illinois Department of Healthcare and Family Services
Access Subcommittee Meeting
November 19, 2012

important context for planning. This category includes questions about how benchmark Medicaid benefits are delivered within a variety of managed care arrangements and also questions and concerns about medical necessity requirements.

The second category of input had to do with the health care needs of the expansion population. Many of the respondents cited the importance of case management and care coordination. These were noted as a crucial factor in promoting client adherence to treatment plans and medication regimens for a variety of serious and disabling conditions. The majority of respondents cited mental health as a primary concern for their service population with conditions ranging from mild stress and relationship difficulties to serious and persistent conditions including major depression, bipolar disorder and schizophrenia. Substance abuse was raised as a serious health concern. In particular, co-morbidity of mental health and substance abuse disorders are common among clients served by the organizations that responded. A variety of chronic health conditions were cited including obesity, hypertension, diabetes, asthma, headaches, pain disorders and arthritis. A few respondents described the importance of fast easy access to highly specialized care for clients with specific and life threatening conditions such as cystic fibrosis and HIV. One respondent noted that the expansion population will include middle-aged persons with pre-existing but non-disabling conditions. Many in this group have been unable to obtain or afford health insurance and will enter Medicaid with more and more advanced chronic health conditions.

Case management and care coordination services were widely recommended for maximizing the impact of primary care, specialty care, pharmacy and other services in the benchmark package. Almost all of the respondents cited the importance of mental health and substance abuse services. Three specific suggestions stood out. Many requested Medicaid look-alike services interpreted as the services covered under standard Medicaid. A few respondents specifically stated that the benchmark package should include access to rule 132 mental health services which are provided by certified mental health professionals. One respondent noted that the state currently expends general revenue funds (GRF) to provide these services to persons with mental illness while awaiting disability determinations and believed the state could realize savings if rule 132 services were covered by the benchmark package. Supported employment, also referred to as Individual Placement and Support, and supportive housing were cited as evidence-based and cost effective services for this and other vulnerable populations. Several respondents emphasized the importance of primary care services to address chronic conditions such as hypertension, asthma, diabetes and heart disease. HFS received many recommendations on pharmacy benefits especially in respect to new prior approval requirements. Many respondents noted the importance of oral health with some specifically recommending the restoration of adult dental benefits and the inclusion of those benefits in the benchmark package. Prevention and wellness were recommended by several respondents as were vision services. A few respondents focused on fast access to specialized care to prevent the advancement of serious illnesses. Finally, a few respondents requested the inclusion of services to prevent aging clients from a decline into disability at which point they would require more costly care under the Medicaid program for seniors and persons with disabilities. Suggestions included services such as medical transportation, medication management, home health-aid services and environmental modifications.

Although the input received represented a small sample of community stakeholders, it is clear that respondents are focused primarily on the essential health benefits which are required in any benchmark Medicaid package. What is less clear is whether services beyond those requirements should be considered. HFS will continue to encourage, receive and review input. Once a benchmark Medicaid package is defined, there will be a required public comment period before HFS submits a proposal to the federal government. The opportunity to see what is being considered and to weigh in will continue until it is submitted at some point next year. As HFS knows more about timing we will share that information.

Discussion

There was a robust discussion on analyzing respondent input, strategies for getting the legislature to authorize the Medicaid expansion, cost analysis supporting the expansion, services to include in the Benchmark Medicaid package, needs of the expansion population, and issues related to the SMART Act restrictions. Some of the discussion is summarized below.

Analyzing respondent input

Mr. Koetting stated that the Director wants to make sure that HFS has collected opinions from people so that our thoughts are not being formed in a vacuum. The Director also wants to make sure that we develop with the broader community a sense of what an appropriate answer would be in the event that we are called on to discuss that. The desire is to get as much thought and consensus as possible. HFS has not yet set the benchmark package but one of the federal requirements is that it covers the ten categories of essential health benefits.

Illinois Department of Healthcare and Family Services
Access Subcommittee Meeting
November 19, 2012

Chairman Pick shared that it is helpful for him to chart or use a spreadsheet to organize the volume of information that was shared from many perspectives, different populations, different service needs and different dynamics for each of the populations. He suggested to spreadsheet information into categories by population, by service need, by specific dynamics of each population so the committee can start to organize the thoughts in a way that becomes actionable and then look at some kind of a format to develop a strategy.

Nadeen Israel advised that it would be helpful to chart which services are ACA mandatory and covered as a category in the essential health benefits benchmark plan.

Mary Driscoll suggested looking at the package of benefit services and to link them to the three broad tenets of the ACA which are to improve healthcare services, to improve population health and to lower the cost of healthcare. Looking at services like care coordination, case management and supportive services for long term care to prevent readmissions, HFS should be prepared to make a case for why services should be included.

The County's 1115 waiver and the template of benefits that have been drafted for that population are most of the services that are covered within the standard medical and behavioral health services package which is currently part of Medicaid. They include the ability to access care, prevention, wellness, primary care services, supportive case management and access to specialized care for more serious conditions. The package mirrors the standard Medicaid package with the largest exception being long term care. John Bouman understood the biggest exception is freedom of choice of provider as there are a limited number of places that a person can get care. Chairman Pick noted that there is a 30 day post-acute benefit.

Strategies for securing legislative authority to establish new eligibility group for Medicaid

The Department's current draft legislation is very streamlined. The bill would have three parts: authorize the new eligibility category, leave the benefit package to rule making, and give an exception to the moratorium on Medicaid expansion.

Director Hamos stated that the plan is to have the legislation drafted and introduced when the legislature is in the veto session which begins on November 27. There would be a shell bill with a number assigned. The sponsorship would reflect the person who wants to sponsor it which the Director believed would be Sara Feigenholtz. Once she is the sponsor, she can introduce the amendment that would become the bill.

Chairman Pick encouraged everyone to rally their troops to get some energy behind this legislative initiative. Organizations at the meeting who had already taken a position on the Medicaid expansion were IPHCA, HDA, Aids Foundation, Heartland Alliance, Thresholds, IMCHC, Shriver Center, United Power for Action and Justice and Citizen Action Illinois. It was noted that some organizations are meeting on November 20 as part of a coalition on this issue.

Director Hamos agreed that it would be helpful for organizations to email their positions for their agencies to the Department. She suggested that once the Department has a bill number and developed a fact sheet, Ms. Moroney can send out a Listserve email to ask people to send a position statement to the Department.

Several people indicated they had spoke with legislators since the election about this plan. Some people are wondering what the House Speaker will do. Another person offered that legislators want to know what kind of support for Medicaid expansion they can put together. Legislators are wondering about economic impact, impact on hospitals, positive impact on clients and the amount of state dollars that can be turned into federal dollars. Mr. Bouman asked what the state sister agencies are spending that is only GRF. He added that Representative Feigenholtz asked for that specifically in anticipation of discussion with the House Speaker's budget staff.

Director Hamos advised that she has started to draft a fact sheet that frames the issue in those sorts of ways. Mr. Bouman stated that a fact sheet that dates back to two weeks after the Supreme Court ruling had been developed. It gives the top ten reasons that Illinois should do the expansion. We need some specifics about certain human services being in the benefit package and the amount of budget savings from accessing the federal support.

Cost analysis supporting the expansion

Illinois Department of Healthcare and Family Services
Access Subcommittee Meeting
November 19, 2012

Mr. Koetting stated that GRF savings are not great as far as the Department can tell. He estimated the top end to possibly be \$100 million. He added that when HFS did the analysis we found that things that could be considered Medicaid had been moved to Medicaid and some things really couldn't be fit into Medicaid.

Director Hamos cautioned that there are things the state has paid for and found necessary to pay for but converting it to a different analysis for what qualifies as Medicaid is a very different question. For example, there is no reason that HFS would believe that supportive housing is a Medicaid service.

Director Hamos asked if it true that when someone applies for SSA disability it can take one to two years for approval and that there are services perhaps GRF funded, provided by agencies during this interim period. It was noted that there is a 24 month waiting period for Medicare, during which time those with pending Medicare benefits often rely on Medicaid.

One response was that those services are being delivered less these days since the package that agencies have of non-Medicaid dollars to support those folks is so restrictive. Unfortunately where cost savings would be if you looked at for example persons with mental illness at Cermak is an increase in the number of persons with behavioral health disorders who have ended up in jail because they haven't been able to get basic services.

Another person responded that within the substance abuse treatment system there is a significant portion of the population that is not covered under Medicaid and portions of the services that are provided are paid partially through Medicaid and partially through GRF. It is difficult to determine what services will be covered and how they will be covered under the new system of Medicaid expansion.

HFS will try to put together some cost savings numbers with the sister agencies to shed some light on determining services that clients are receiving that are being funded through GRF as there are no Medicaid funds for them now.

Debbie Pavick asked if it would helpful to look at what services were delivered with GRF before they were taken away. For Thresholds, it was about 10% of the budget. Two to three years ago the amount of GRF that was going for the care of this population was between 4 and \$5 million. The amount was capped so the agency could have spent more. These were for rule 132 services for persons with disabilities and included mostly community support and individual therapy to help rehabilitate a population by helping them keep appointments obtain and maintain housing, manage money and connect to primary care. Looking at where the GRF dollars were going then would let us know what GRF previously could be covered by the feds going forward. It would be useful to get the number of persons served from DMH.

Services to include in the Benchmark Medicaid package

Sharron Mathews, HFS Assistant Director, stated that home health care was something that should be considered as part of the benchmark package, and noted that persons have not responded to the survey still have time to do so.

Ms. Moroney commented that HFS did get some survey input on home health aide services, and that she had learned that those services are currently available in the standard Medicaid package. Ms. Moroney's understanding is that the obstacle to patient access to home health services is that there is more demand than there are providers to deliver them.

Mr. Bouman suggested that HFS look at what we give to the ineligible population like substance abuse counseling and case management that could be covered under Medicaid if they were eligible.

Currently men on Medicaid are not typically reimbursed for residential services because the majority of beds in our system do not meet the IMD exclusion.

Director Hamos summarized that there are services that have not been eligible for reimbursement under Medicaid that are very important and useful but Medicaid has not yet created that as part of the service packages for regular Medicaid. It is hard to believe that the federal CMS would create new exclusions for the newly eligible Medicaid.

Mr. Bouman suggested thinking about the populations that will be covered who are getting services from other branches of government that might be included under Medicaid such as discharge services under the Department of Corrections or children that age out of Medicaid and receive counseling services through community colleges.

Illinois Department of Healthcare and Family Services
Access Subcommittee Meeting
November 19, 2012

Services for the newly eligible would not likely be different from those that have Medicaid now. The various utilization controls put in place under the SMART Act would apply also to the package of services for newly eligibles.

Erin Weir noted that the Director was using the FamilyCare category as an example of the standard benefit package. She is concerned about the portion of the population in the group 55 to 64 years of age and some of the services that those people might need and the cost savings. It may be helpful for us to tie the savings into the Colbert decree. If we provide these services to people in the community, we may prevent them from ending up in long term care. Consider a 63 year old woman who doesn't qualify for Medicare and doesn't meet the definition of disabled. If that woman has enough chronic co-morbid conditions she could eventually end up in long term care facility spending down her assets and ultimately qualifying for the existing SPD category. For example if she has diabetes and is not receiving primary care services to manage her diabetes, she may need significantly more care, go into long term care and eventually be approved as SPD eligible. HFS may want to use the example as a cost savings argument for the legislature.

Director Hamos stated that she understands the goals and thinking but pointed out that diabetes care is part of the ten essential health benefits. She asked what the woman would need beyond the essential health benefits.

Chairman Pick pointed out that there are their community care programs specifically directed to person under 65 that qualify for Medicaid for community programs that support their ability to remain in their own homes and prevent them from ending up in a long term care facility on Medicaid. Things like home maker services and meals on wheels that are currently covered under Medicaid under the waiver programs could fit.

Chairman Pick noted that there might be a sizable group of people with intermittent disabilities such that they would not be determined disabled but still require some intensive services. He stated that there are two parts to consider. One is the disability may be severe enough to qualify but the condition is not permanent. The other is the condition doesn't reach the threshold of qualifying for federal disability but their dependencies if left unsupported will deteriorate further and the patient ends up needing permanent support.

Director Hamos stated that the nuance of developing that kind of policy is to figure out who would qualify for that based on what level of disability. If it is not our current system of full disability which has a whole process all by itself, then what is the other level of disability? The Department understands the theory but the operational questions are how we define that, who qualifies for that remembering that there is no asset test. We would need to ask what the services are and what the utilization controls are for that. If you have an idea on that and would like to craft something and think it is worthwhile to consider, it is something that needs to be figured out as you can't just create a policy without understanding all the operational and practical implications.

Director Hamos asked organizations that have done some of that research and have data showing cost savings as well as who should qualify should send their information to Ms. Moroney. She requested not the theory of cost savings, but data that would inform a rule and its implementation.

Persons who fall into the SPD category and become eligible for Medicaid may not be on SSI disability for two years. Without SSI, even with Medicaid, they will not be able to purchase housing. This will end up costing Medicaid more because the person is going to go into the hospital or ED. Is there some way to tie getting a Social Security determination sooner for the newly eligible that fall within the SPD category? We know from the research that housing is a determinate in helping to reduce a person's healthcare cost. Once people get SSI, it is possible to pay for their housing. Without that the person is more likely to continue to use the ED or go in-patient to a psychiatric hospital or IMDs because they do not have housing.

Director Hamos suggested that a paradigm shift might be that HFS is going to provide additional services to support employment. So opposed to getting SSI and becoming disabled, try to move the person into the workforce so they will have dollars to purchase their housing. This is a shift in that in the past the only way to get them healthcare was that route and now we are going to provide them a different route.

Chairman Pick stated that the Director was raising a very important question and that is not just on the housing and social aspects but also now that they are going to have a benefit that they haven't had before, they don't know how to use it. How do we educate and train individuals who have never had any form of health insurance before to learn how

Illinois Department of Healthcare and Family Services
Access Subcommittee Meeting
November 19, 2012

that impacts the way they have to live? The paradigm shift also includes that now that they have a benefit how do you manage it? This is another question that the access committee could work on.

Issues related to the SMART Act restrictions

Mr. Huggett stated it would be nice to include some of the services that were cut back under the SMART Act and previously offered like adult dental care, more mental health care and less restriction on prescriptions.

Director Hamos stated that she would try to frame this in a different way. FamilyCare adults are not disabled, do not have an asset test and they get a medical service package. One question that is on the table for the newly eligible men, who are income tested but no disability or asset test, do they get the same service package as the FamilyCare adult? Also, is that pretty closely aligned to the health insurance products that will be sold on the exchange which are basically the same ten essential health benefits? So that for that group that will go back and forth between Medicaid and private insurance in that low income category will still qualify for a lot of the same package of services. Director Hamos would maintain that the minimum essential benchmark Medicaid plan as the feds have written it without giving us any rules on that is a lot like the FamilyCare adults.

She added that the question raised about adult dental is an interesting one.

James Parker, Deputy Director of Operations stated that he doesn't think that anyone has conceived that the package for the new eligible would be more generous and could only conceive of giving those benefits to newly eligible if they were given back to the existing population.

Ms. Israel stated that many persons strongly believe the benefits like adult dental care should be restored for the current Medicaid and added for the new Medicaid group. She thought that something to think about is the impact on the individual's health and the cost savings that we are trying to get over the long term. She believes that our past experience showed that we didn't do so well in terms of cost savings by limiting adult dental care.

Mr. Huggett stated that he is wondering how the Department is getting feedback about cost savings, especially on the restriction of medications. He shared that 2 weeks ago he hospitalized a patient with severe rheumatoid arthritis as she couldn't get her medications for about a week. A prior approval application had been made, forms filled out and sent to Springfield and then sent to the pharmacy. The patient couldn't get prednisone or other pain medications for a week.

He asked what the mechanism is to report this type of situation. He suggested a hotline number or email address to report this kind of thing. Maybe advocacy agencies can publicize through the professional agencies so providers can give that feedback. He noted that the state is not saving money by delaying medication then people go to the hospital.

Mr. Koetting suggested looking at specific cases and getting the information to him and HFS staff will get the report to the proper people for review. The Department would figure out exactly where the problem is and correct it so the Department can live within the law and at the same time not deny clients the care they need.

Chairman Pick suggested that we do a root-cause analysis as we know the outcome but not if the root-cause was the policy or the application of the policy. We need to assemble specific case information where this is the outcome and then spend some time doing the root-cause analysis to understand what specific elements of the system broke down.

Christy Serrano with Ounce of Prevention asked if a separate category could be set up for pregnant women so they could receive dental care. The state of California has done this for the perinatal period. Perhaps the group would be interested in looking at this and the cost savings found in other states.

Director Hamos responded that what Ms. Serrano is reflecting on are the SMART Act restrictions. Right now the legislature may not be willing to reopen the SMART Act to look at making adjustments but it may happen in the spring. She stated that the Department would like to get her feedback and to email it along with case examples in other states.

7. Subcommittee logistics

Meeting frequency, timing and locations

Members of the committee and the Department discussed the logistics and it was recommended that:

Illinois Department of Healthcare and Family Services
Access Subcommittee Meeting
November 19, 2012

- HFS would work with the Governor's office in convening a legislative organizing meeting for the week of December 10th. The Department would invite all the members of the Access committee and others stakeholders as well.
- The next best time for the Access subcommittee to meet would be early next year.
- Chairman Pick and Ms. Moroney would work on putting together some possible dates in January. He stated that timing could be decided at the next meeting and that the Chicago and Springfield locations have been working so far.

8. Conclusion

Agenda for next session

Mr. Bouman stated that he would like to see some reporting on the roll-out of the eligibility verification process. He advised that there are some predictions that there will be a large bubble of determinations of ineligibility due to a backlog of redeterminations. He believes that it would be useful to watch how that is going and that it is truly about eligibility and not about hiccups in the process or staffing shortages.

Chairman Pick was not sure if Mr. Bouman's topic suggestion is an access issue for the MAC, this committee or both. He advised he would keep that on the agenda for discussion. He asked if there were any other topics that persons would like to see on the next meeting's agenda.

Assistant Director Mathews stated that she would like to see whatever feedback the Department receives on community care placed on the agenda.

Review Action Items

Ms. Moroney reminded participants that HFS relies heavily on the MAC Listserve to support communications to subcommittee members. She encouraged persons that have not found messages in their mailbox from the Listserve, or are having difficulty receiving the email messages to contact her.

She summarized the follow up actions as she and Chairman Pick working to establish a meeting date for the Access subcommittee sometime in January 2013 with meeting notice draft agenda and draft minutes for today's meeting and the October briefing session out ahead of time.

HFS will coordinate with the Governor's office on a legislative organizing session to which MAC Access subcommittee members will be invited.

9. Adjournment

The session was adjourned at 12:52 p.m.