

**ILLINOIS DEPARTMENT
OF HEALTHCARE AND FAMILY SERVICES**

ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

Fiscal Years 2009, 2010 and 2011

Submitted March 30, 2012

To the Honorable Pat Quinn, Governor

And Members of the General Assembly:

It is with pleasure that we present to you the Department of Healthcare and Family Services' Medical Assistance Program Annual Report for fiscal year 2011. This document consolidates the reporting requirements under Sections 5-5, 5-5.8 and 5-5-29 of the Illinois Public Aid Code (305 ILCS 5/), Section 55 of the Disabilities Act of 2003 (20 ILCS 2407/) and Section 23 of the Children's Health Act (215 ILCS 106/).

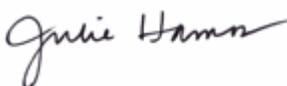
This report provides details on specific programs, participant numbers, and provider reimbursement. Medical Assistance Program information is provided for the most recently completed fiscal year 2011 and the two previous years, to allow for comparisons for purposes of trending the services. Long term care-specific information is also contained for fiscal year 2011 in compliance with reporting requirements.

This report also contains updates on the Department's efforts in implementing Illinois' Medicaid reform legislation [*P. A. 96-1501*] that have occurred since April of 2011. It has been a very challenging, enlightening and productive year. The Department has made great strides in implementing Medicaid reform, while at the same time planning for the changes coming under the federal Patient Protection and Affordable Care Act (*Pub.L. 111-148*). We believe that enhanced coordination of the care our clients receive is the strategic key to a more efficient Medicaid program that still provides care for the most vulnerable among us. A few of the reform milestones the Department achieved include:

- In June of 2011, published [Coordinated Care Discussion Paper \(pdf\)](#) outlining many of the issues that the Department was considering in developing an implementation plan for Medicaid reform. We received about 75 responses representing a variety of organization, opinions and options. The responses can be viewed on-line at [Coordinated Care Policy Forum Responses](#).
- In October of 2011, the Department held a public meeting and Webinar, attended by over 1,000 people, to test community interest, and capacity to provide alternative models of delivering care (as an adjunct to our current managed care programs). The purpose of the meeting was to provide the department with feedback on its proposed concepts to use in the planning and development for this project.
- In January 2012, issued the first solicitation for the Care Coordination "Innovations Project."
- Created the Care Coordination Matchmaker service, a voluntary Internet based system to help community partners find each other in order to develop potential collaborations for the Innovations Project solicitation.
- Released an unprecedented quantity of data and documentation to allow healthcare organizations proposing new Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCNs) to create high-quality, accessible, and cost-effective healthcare programs for Medicaid recipients.

We hope you find this report informative and useful as we work together to continue providing quality healthcare services to Illinois' most vulnerable populations.

Sincerely,



Julie Hamos, Director
Department of Healthcare and Family Services



Theresa Eagleson, Administrator
Division of Medical

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I. OVERVIEW

The Department of Healthcare and Family Services (HFS), Division of Medical Programs, administers and, in conjunction with the federal government, funds medical services provided to about 20 percent of the State's population. In fiscal year 2011, Medicaid, and the means tested medical programs associated with it, provided comprehensive health care coverage to approximately 2.74 million Illinoisans and partial benefits to over 300,000.

The Medical Assistance Programs are administered under the provisions of the *Illinois Public Aid Code (305 ILCS 5/5 et seq.)*; the *Illinois Children's Health Insurance Program Act (215 ILCS 106/1 et seq.)*; *Covering All Kids Health Insurance Act (215 ILCS 170/1 et seq.)* and *Titles XIX and XXI of the federal Social Security Act*.

Through its role as the designated Medicaid single State agency, HFS works with several other agencies that manage important portions of the program—the Departments of Human Services (DHS); Public Health (DPH); Children and Family Services (DCFS); the Department on Aging (DoA); the University of Illinois at Chicago; and Cook County and other local units of government, including hundreds of local school districts.

Illinois' Medical Assistance Programs are almost all funded jointly by State and federal governments and, in certain instances, local governments. The Department spent in excess of \$13.3 billion (all funds) from fiscal year 2011 appropriations, of which \$10.28 billion was GRF/GRF like funds and approximately \$5.7 billion was federal matching funds, on health benefits provided to approximately 3.1 million individuals over the course of the year.

Medical coverage is provided to children, parents or relatives caring for children, pregnant women, veterans, seniors, persons who are blind, and persons with disabilities. To be eligible, adults must also be Illinois residents and U.S. citizens or qualified immigrants. (Immigrants who are not permanent legal residents may be covered for emergency medical care only, and are not eligible for transplantation services). Children are eligible regardless of immigration status. Individuals must also meet income and asset requirements. Income and asset limits vary by group. Major eligibility groups and brief descriptions of HFS' programs are described in Appendix A of this report.

On average, each month HFS' programs cover approximately 2.7 million enrollees for comprehensive coverage, including close to 1.7 million children, 168,000 seniors, 260,000 persons with disabilities, 636,000 non-disabled, non-senior adults and approximately another 297,000 enrollees with partial benefit packages (such as Illinois Healthy Women, Illinois Cares Rx pharmacy assistance, and insurance premium rebates). The table below shows enrollment as of June 30th for the last three fiscal years.

Comprehensive Benefits	FY2009	FY2010	FY2011
Children	1,553,255	1,630,495	1,677,575
Disabled Adults	244,598	253,973	260,228
Other Adults	563,068	608,659	636,531
Seniors	152,894	161,356	168,943
All Comprehensive	2,513,815	2,654,483	2,743,277
All Partial Benefits	280,067	294,039	309,387
Grand Total All Enrollees	2,793,882	2,948,522	3,052,664

II. MEDICAID'S FUTURE – CARE COORDINATION

Care Coordination — aligned with the Illinois Medicaid reform law and the federal Affordable Care Act — is the centerpiece of the Department's reform efforts. In moving forward, HFS recognizes that the transition from a fee-for-service payment system more accountability based payment system will require major changes for the provider community and clients. Under the new "Medicaid" there must be an infusion of risk and performance into reimbursement in order to transform the Medicaid healthcare delivery system with a focus on improved health outcomes. To accomplish this, the Department has laid out an ambitious timeline for the development of its Care Coordination initiatives:

January, 2012

- ◇ Innovations Project: issue solicitation with initial focus on adults with complex health needs served by provider-driven models of care only (i.e. not traditional HMOs). Provider collaborations must include, at a minimum, hospital(s), primary care provider(s), and behavioral health program(s).

Spring, 2012

- ◇ Innovations Project: issue solicitation to include children with complex health needs and high-risk moms and babies.
- ◇ Expand the Integrated Care Program (ICP) to include long-term care services, for the approximately 40,000 enrolled Seniors and Persons with Disabilities (SPDs) clients who reside in suburbs/collar counties. (Phase 2 services)
- ◇ Issue proposal for integrated care models to serve approximately 200,000–250,000 dual-eligible (Medicare/Medicaid) clients under dual-capitation.

Fall, 2012

- ◇ Expand Care Coordination Innovations Project to include care coordination entities of all types, including traditional HMOs.

Care Coordination Innovations Project

The Medicaid reform law, *Public Act 96-1501*, requires the Department to move at least 50 percent of recipients eligible for comprehensive medical benefits in all programs administered by the HFS to a risk-based care coordination program by January 1, 2015.

Illinois' goal for the future is a redesigned health care delivery system that is more patient-centered, with focus on improved health outcomes, enhanced patient access, and patient safety. To meet the State goal, the Department, in collaboration with other State Agencies and community partners developed the Care Coordination "Innovations Project". The Innovations Project is designed to meet the state's goal by: testing community interest and capacity to provide alternative models of delivering care; aligning with federal Accountable Care Act initiatives; incorporating feedback from stakeholders; and building on interagency collaborations.

The first step in reaching this goal is the release of the Solicitation for Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCNs) for Seniors and Persons with Disabilities (SPDs). SPDs with complex health/behavioral health needs (about 16 percent of HFS' clients) account for approximately 55 percent of the Medicaid budget (all agencies).

The Department released a solicitation seeking qualified and financially sound Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCNs) to enter into contracts to coordinate care for priority populations across the spectrum of the healthcare system with a particular emphasis on managing transitions between levels of care and coordination between physical and mental health. The solicitation was developed by the Office of the Governor, DHS Divisions of Mental Health, Substance Abuse, Developmental Disabilities, and Rehabilitation Services, the Department of Healthcare and Family Services and the Department on Aging. This solicitation fulfills a goal to allow providers to design and offer care coordination models other than traditional Health Maintenance Organizations (HMOs). The Department is looking for innovative proposals demonstrating that providers can provide equal or better care coordination services, produce equal or better health outcomes and render equal or better savings than traditional HMOs. In the absence of such successful models, the Department will fulfill the statutory mandate through traditional HMOs.

Coordinated Care in Illinois is contemplated to include a wider range of potential arrangements than traditional, fully capitated managed care. CCEs would be organized by hospitals, physician groups, FQHCs or social service organizations. Proposals for CCEs and MCCNs are due to the Department by May 25, 2012 with an expected implementation on January 1, 2013.

The state is expecting proposals that engage community partners in promoting coordinated quality care, across provider and community settings; offer new risk-based funding incentives and flexibilities; and measure delivery system effectiveness and efficiency. CCE project collaborators must include participation from Primary Care Providers (PCPs), hospitals, and mental health and substance abuse providers.

Priority populations include SPDs (including those in long-term care, those with serious mental illness, and waiver populations); and individuals with Medicare (including duals and long term care). Integrated Care Program clients are excluded from enrollment in CCEs and MCCNs. Enrollment in a CCE or MCCN will be voluntary.

A second solicitation to serve Children with Complex Medical Needs is also in progress. The program is under development and the solicitation is expected to be released sometime in May 2012. Refer to *Section III. Children's Programs* for additional information on this initiative.

In addition, work has begun on a Medicare/Medicaid Financial Alignment initiative to integrate care for both Medicare and Medicaid under one managed care program. This initiative will integrate Medicare and Medicaid financing streams to eliminate conflicting incentives between the two programs. The goal is to integrate benefits to create a unified delivery system that is easier for beneficiaries to navigate. HFS and the federal Centers for Medicare and Medicaid Services (CMS) will contract with Managed Care Entities that will assume financial risk for the care delivered to dual eligible beneficiaries with responsibilities for robust care coordination efforts where performance will be measured and tied to quality measurement goals. The targeted areas for implementation of this initiative are Northeast Illinois and Central Illinois. HFS expects to release the Request for Proposal in the spring of 2012.

Rate Redesign

To pursue better care healthcare outcomes, the Department's reimbursement structures for many providers need to be updated and redesigned – the largest of which are nursing facilities and hospitals.

Hospitals

The Department has embarked on a collaborative approach with the broader provider community. Beginning in March 2011, HFS initiated a dialogue on the development of a reimbursement system for both hospital and long-term care that better promotes coordination of care and quality outcomes. Better management of care should result in more efficient use of State resources by focusing funds on those aspects of care providing the highest return and, in truth, by focusing funds on currently underfunded areas critical to achieve better management of care. This, in turn, can act as a lever to stabilize the cost of care to Medicaid program as well as the private payer and commercial payer community. In order to achieve this, the Department must restructure its reimbursement methodologies to take into consideration the complexity of health care needs, the quality of care and the health outcomes of enrollees. A hospital Technical Advisory Group (TAG) consisting of CEOs, CFOs, and consultants representing numerous hospitals and hospital systems across the state, was established in July of 2011. To date, there have been nine TAG meetings, at which the Department has shared conceptual ideas of updating the reimbursement system, asked for input from the members and addressed provider concerns. In an effort to maintain a transparent process, the Department has published all presentations and materials from the TAG meetings on the HFS website, along with a FAQ document providing the Department's response to individual TAG member questions.

Throughout the hospital reimbursement reform process, the Department's technical consultants have been processing historical claims through the agreed upon systems – the All Patient Refined Diagnosis Related Grouping System (APR DRG) for inpatient and the Enhanced Ambulatory Patient Grouping System (EAPG) for outpatient – to model the payment structure of the proposed system. This is an ongoing task as the Department makes changes to the system by incorporating adjustments derived from analysis and from input collected through the TAG meetings, in order to find the appropriate balance of reimbursement levels across the different types of services and providers.

Nursing Facilities

P.A. 096-1530 sunsets the current reimbursement structure for nursing facilities and directs the Department to develop a replacement structure for implementation on July 1, 2012. It is the Department's intent to implement a reimbursement system that will be linked directly to an individual's resource utilization needs and promote quality care and healthier lives for the disabled and frail residents who require nursing facility care.

In 2011, the Department engaged a dialogue with representatives of the nursing home industry on the development of a new reimbursement system that is evidence-based and reflective of the needs of individual nursing facility residents. Work continues on these efforts.

III. CHILDREN WITH COMPLEX MEDICAL NEEDS

As required in the Medicaid reform law [P.A. 96-1501], the Department established a stakeholder group for advocates, providers and funders of care to collectively explore program design and delivery systems for children with complex medical needs to lead to more efficient, economical and consumer directed services. The group focused on children with chronic conditions and medically complex children with high cost in-home services. Analyses of the program and recommendations on program changes care are summarized below. Overview of the waivers, amendments, services and expenditures may be found in Section IX. This Section of the Annual Report is the final report as required by law.

Stakeholder Meetings

Seven stakeholder meetings were held between June 2011 and February 2012. Information on the stakeholder groups may be found at: <http://hfs.illinois.gov/ccmn/>

Meeting discussions focused on what is and what is not working in the care delivery system for children with complex medical needs and what components a new system should include. Extensive discussions included topics on the universe of children to be served; acuity levels that may drive the service levels and payment system; how to incentivize care coordination entities; range of services that would be covered by care coordination entities; creation of an unique provider type to provide tasks normally provided by licensed nurses; and cost-sharing by parents to pay for services. The last meeting focused on performance outcomes unique to children with complex medical needs.

1. General Consensus of Participants

Participants agreed on several key design points as described below.

Care Coordination (CC)

There was general agreement among the participants that care coordination is a key component for managing care for children with complex medical needs (CCMN). Recognizing the difficulties in identifying children with chronic conditions and high costs, two care coordination options were recommended: 1) a program for children who are ventilator or technology dependent; and 2) one for all other children with multiple chronic conditions.

The first CC program would utilize the Division of Specialized Care for Children (DSCC) as a Single Point of Entry (SPOE) to provide care coordination for all children with complex medical needs seeking in-home services. This will include children currently served under the Medically Fragile, Technology Dependent (MFTD) waiver as well as other children receiving private duty nursing in the home through Nursing and Personal Care Services, which may include children served in other waivers and through the Department of Children and Family Services (DCFS). For the children receiving in-home services, there will be two levels of assessment, 1) eligibility, and if eligible; 2) a further review (comprehensive assessment) to determine risk, develop a plan of care and to determine care coordination intensity levels. It was recommended that the eligibility and resource allocation would be determined separately from care coordination.

The second CC program would provide care coordination for all other children with "multiple" chronic conditions through a Care Coordination Entity (CCE) or Managed Care Community Network (MCCN). As with the Care Coordination Innovations Project serving adults with complex conditions, a second solicitation will seek proposals for CCEs and MCCNs to serve children identified with multiple chronic

conditions or high resource utilization; but, are not in need of home services. Children would be identified through the Department's Client Enrollment Broker and offered enrollment in a CCE specifically designed to meet their needs. Children would receive care coordination either through the CCN/MCCN or DSCC, but not from both programs. Participation in CCE/MCCN programs would be voluntary.

Cost Sharing

There was general consensus among the participants that cost sharing is needed to preserve the program and to incentivize a philosophy of shared responsibility.

New Provider Type

There was general consensus among the participants that a work group be initiated to explore establishing a new provider type to be specifically trained for providing nursing care to children with complex needs.

The major areas of discussion and program analysis from the seven stakeholder meetings are described below under topics 2 through 11. Topic 12 outlines the next steps for this initiative.

2. Components of a new system for Children with Complex Medical Needs

The group discussed the following system changes needed to serve children with complex medical needs. The group recommended a SPOE, but recommended a separation of eligibility determination and care coordination and a separate entity for quality oversight to prevent conflict of interest. The following is an overview of the participants' suggestions:

Point of Entry (Access and Referral)

- SPOE, such as an agency, managed care entity, or independent entity – where there is single web site, phone number and email address for access.
- Assuring access to the SPOE statewide, such as regional offices as long as standard processes are used.
- Specifically define the population to be served such as all seeking private duty nursing or other medically complex care
- The SPOE should have electronic capabilities of accessing and sharing information needed to track individuals through the application, referral and service implementation.

Eligibility/Assessment of need for services (assuring necessary services)

- The system should include a screening process, referral system for individuals not eligible and a more comprehensive assessment of need for services for those who are deemed eligible.
- Medical necessity needs to be objectively defined considering federal guidance.
- The assessment needs to include medical, psycho-social, environmental and other components as outlined by International Classification guidelines.
- Eligibility determination should be separated from delivery of services and care coordination to avoid conflict of interest.
- The level of services and types of providers should be identified through an objective assessment for all seeking private duty nursing, regardless of age or agency responsible.
- The assessment should identify risks, back-up systems and level of care coordination needed.
- Consideration for outliers should be incorporated along with a human review component.

- Evaluators should be qualified and well trained.
- Triggers for reassessment should be developed that more promptly address changes in condition.

Services (flexible and based on all partners working together)

- Services should be based on medical need and a prior approval system that includes either a predictive modeling tool or a defined method to objectively and consistently identify needs for all applicants.
- Payment stratification based on levels of complexity of care should be considered to more appropriately target resources to those with the most complex needs.
- Explore creation of a distinct unlicensed provider type that through client specific training and oversight may allow reduced reliance on licensed staff.
- Option for consumer direction should be included to allow for more flexible use of resources such as allowing families to save hours and use later, like rollover minutes for cell phones.
- Service plans should be flexible enough to adjust services promptly if more hours are needed to prevent hospitalizations or to address other medical needs.
- Sharing resources or pooling resources should be explored such as two families who live in close proximity sharing the same nurse in a day care like fashion.
- Individuals with higher medical needs should be supported appropriately.
- Telemedicine should be utilized more extensively including remote monitoring.
- Services that are reduced should include weaning of hours and discussion of changes before implementation.
- Nursing agencies must be involved to promote independence, reduce reliance on paid services and report changes promptly to care coordinators.
- Training programs for certain services (e.g., ventilator care, trach care) should be developed to assure appropriate understanding and service delivery.

Care Coordination (Expanded role and responsibility)

- Each eligible participant should choose or be assigned to a care coordination entity.
- The level of care coordination should be recommended through the assessment process and be flexible and dynamic increasing or decreasing with changes in condition.
- CCEs must coordinate all care for the child including promoting health, facilitating linkages to services, assuring follow-ups, assisting with housing issues as needed, consider social factors and family dynamics, interfacing and coordinating with other agencies providing services, and identifying changes in condition, Emergency Room or hospital use to promptly address changes in care.
- Care coordination should continue through the life continuum based on individual needs.
- Electronic sharing of services and care coordination activities are essential.
- CCEs must educate all partners including clinical staff, service staff, families and others on maximizing independence and reducing the reliance on paid services.

Quality Improvement (Outcomes drive system changes and all partners involved and informed)

- Performance indicators should be developed to assure care coordination meets the needs and improves health outcomes.
- Ongoing training of all partners should be established and monitored.
- Health outcomes and cost of care (utilization review) should be analyzed and used to drive reimbursement or program changes.
- Stakeholders should have access to resources that will inform them on the success of the program and the opportunity to report program experiences.
- Interagency alliances must be formed to partner in the changes needed to develop and oversee services.
- An independent entity should monitor quality improvement.

3. Universe of children to be served

HFS shared a summary of Net Liability for Children under age 19 grouped by ranges of expenditures. The groupings were from zero expenditure with incremental increases up to over \$999,000 per year per child. The chart included the net liability amount for the number of children in the range, the average liability per recipient and the cumulative percent of liability for the group. Also included were children with multiple complex chronic conditions as identified by ICD-9 codes, children receiving private duty nursing who were in the Medically Fragile, Technology Dependent waiver and children receiving private duty nursing who are not in a waiver.

It was noted that .15 percent of the 1.8 million served were responsible for over 20 percent of the total net liability. Higher cost children did not necessarily use in-home care. HFS has identified that many of the high cost children include those with high pharmacy costs for hemophilia treatments, high inpatient costs for pre-terms, malignancies and transplants. Although high costs may not predict the in-home need supports, ongoing analysis of liability is an essential part of the program development for care coordination.

4. Acuity levels that may drive the service levels and payment system

Discussion Highlights

- If the eligibility is initially established by a third party, a reassessment should be done by care coordinators who know the service needs in the home within a 60 day period and periodically with annual reviews by the third party.
- Assessments done while in the hospital may not accurately reflect needs in the home.
- Triggers for frequency of reassessment and flexibility of reassessments and service plan changes should be established.
- Point systems may be needed, but there needs to be a human component in determining levels of care as well.
- Other care needs such as disability related and mental health services should be considered in the overall plan and care coordination.
- Durable medical equipment should be coordinated.
- Respiratory Therapists should be included for those on ventilators.
- Service packages that offer flexibility should be considered.
- Utilization of services should be analyzed and considered.
- Screening and assessment tools should be re-evaluated after one year.
- Another level of care for a non-nurse provider may need to be considered.
- Children in the home service programs may be potential candidates for the population served.

- Explore paying parents to provide care, while considering back-up systems and preventing creation of dependence on family and situations where children are not willing to accept care from someone other than parents.

5. How to incentivize Care Coordination Entities (CCE)

Participants' Suggestions

- Identify geographic locations of children with complex medical needs.
- Establish higher reimbursement for seeing children closer to their homes, moving out of centers and into the community.
- Promote telemedicine.
- Must include a care coordination lynch pin, for example, clients respond to what physician tells them, so care coordinator must be connected to the physician.

6. Range of services that would be covered by a CCE

Participants' Suggestions

- Primary Care and Specialists.
- Care Coordination Nurse – coordinating communications, linkages, and follow-up.
- Hospital services.
- Durable medical equipment.
- Respiratory Therapists (available for those on ventilators).
- Therapies.
- Social service agencies (e.g. Early Intervention, Mental Health, Alcohol and Substance Abuse, etc.).
- Personal attendant care in the home.

7. Options for a unique provider type to provide tasks that are normally provided by skilled nurses

Several of the meetings included discussions of creating a new provider type to be specifically trained for providing nursing care to a child.

AARP recently published a report on states that provided a list of 16 services in the home ranging from ostomy care to ventilator care. Five states provide all 16 services in the home either through delegation or through consumer direction programs. AARP indicates that several states have voiced interest in developing more expansive delegation programs and they will be offering some joint meetings on this subject in the near future. Illinois will be invited to participate.

One participant doing business in several states shared recent experiences of delegation of nursing services to unlicensed staff in New Jersey. This state worked closely with the nursing association, nursing board, nursing agencies and families to create specialized training for unlicensed nursing agency staff through a nurse delegation process. The pilot was a success, but New Jersey decided to move to a Medicaid Block grant and lowered its eligibility from 200 percent of the FPL to 133 percent.

Participant and Family Feedback

- Need to address what we need to do to keep children out of institutions.
- The cornerstone to establishing the need for services is defining medical necessity.
- Developing a system that includes telemedicine, ready access to licensed staff and an infrastructure that will support using non-licensed staff safely.

8. Family Cost Share and Income Caps

In response to budget concerns and the sustainability of this program, the group was asked to consider the impact of parental share or income caps for participation in the program and how parental share and cost caps could be reasonably applied to families with higher incomes. The participants were informed that the federal government imposes cost share limits for state and federal partnership programs. With certain exceptions, the federal government generally allows states to apply cost share based on the lesser of five percent of family income or 20 percent of the cost of services on families with income over 150 percent of the federal poverty limit (FPL). For state only programs there are no federal restrictions on cost share. Department analysis estimates that approximately 160 of the 650 children served in the Medically Fragile, Technology Dependent (MFTD) home and community based services (HCBS) waiver have incomes over 150 percent FPL. The cost share approach for Medicaid eligible families is unlikely to produce significant revenue, but is a philosophical approach showing an effort for participants to contribute toward care and share in the cost when their incomes are above the Medicaid eligibility limits. Data analysis has shown that home based services are not always less expensive than residential services. Further discussion included the following comments.

Participants' Feedback

- There was general consensus that some type of cost share would be reasonable if the following were considered:
 - Other costs of care for special needs such as over the counter medications, certain durable medical equipment, specialized clothing, home modifications, assistive technology, co-payments for insurance
 - Reasonable consideration of income caps, so that those with modest incomes are not forced to quit jobs, cannot seek services or drop private insurance.
 - The adjusted gross income and other deductions are considered in establishing a cost share amount.
 - Need to look at parental share across community and institutional settings, not just in home services.
 - Before implementation, analyze dollars saved versus what may think will saved.
- Child care costs for most families average \$12,000 to \$15,000/year which is not an expense to families in the waiver.
- Consequences of eliminating the waiver are unknown and children could end up costing more if hospitalized, families could drop insurance and quit jobs.
- Health insurance companies need to be responsible for more of the care as almost universally; private duty nursing is not paid through insurance but should be if medically indicated.

9. Mental Health Interface with Care Coordination Innovations

Several voiced the importance of behavioral interventions and questioned how care coordination would interface with the current Screening, Assessment and Support Services (SASS) program. Though the definitive policy on this is still being considered, CCE/MCCNs are expected to identify the target population and service package that they will be responsible for supporting through their network of providers. Once an individual is part of a CCE/MCCN, that program would be responsible for delivering the medically necessary care required, including behavioral

health crisis intervention services. Children served under a CCE/MCCN would likely be similar to children and youth with parents that have elected to be part of an HFS funded Managed Care Organization (MCOs). Children currently served under MCOs are not eligible for enrollment into the SASS program.

10. Performance Outcomes for Care Coordination

Performance outcomes were shared from the January 23, 2012 Solicitation for Care Coordination Entities and Managed Care Community Networks for Seniors and Persons with Disabilities. The final Performance Outcomes may be accessed under Attachments A and B of the [Solicitation for Care Coordination Entities and Managed Care Community Network for Seniors and Adults with Disabilities](#)

The January 23, 2012 solicitation has two sets of performance measures. One set collected on everyone based on persons served and the second set was linked to pay for performance (P4P), or a share in savings. The first 10 percent of cost savings is automatically shared, with the remaining 40 percent distributed in 10 percent increments in four P4P areas: 1) access to member's assigned primary care physician, 2) follow-up with a provider within 30 days after an initial behavioral health diagnosis, 3) medication therapy management. Medication review of all enrollees taking more than five prescription medications and 4) a proposed measure offered by the entity and approved by HFS. Risk adjustment will be used in analyzing outcomes.

Other performance measure specifications can be accessed at: [Performance Measure Specifications for the Care Coordination Program \(pdf\)](#)

Performance measures from the Department's voluntary Managed Care contract for children were also shared. The contract may be accessed at <http://www.hfs.illinois.gov/assets/mco.pdf>

Participants' Feedback

- Suggest adopting the *Children Health Insurance Program Reauthorization Act of 2009 (CHIPRA)* measures.
- Outcomes measured may vary based on populations served.
- Need to define success – cost savings, length of stay reductions, etc., as success for the state may be different than success for families.
- Need to consider outcomes desired by families and start with input from families – outcomes should be fueled by the plans of care.
- Need to define what is important, what to measure and how to measure.
- Establish a focus group to design the structure.

The last stakeholder meeting on February 10, 2012 focused on performance measures for care coordination of the in-home group as proposed to be served by DSCC and those with multiple chronic conditions who would be covered under the children's care coordination solicitation to be issued in the spring of 2012. The recommendations for the two care coordination options follow.

11. Performance Measures for Care coordination of in-home services

Most of the recommendations were focused on process outcomes. DSCC has drafted additional performance measures for: monitoring of intake; monitoring and assurances of well-child exams; immunizations, and; preventive dental exams. The participants offered the following recommendations:

- Analysis of reasons for emergency room and hospitalizations (unfilled shifts, hard to staff cases, safety, failure to be seen within 7 or 14 days of hospitalization).

- Require specialty credentials for nursing agencies providing pediatric and technology care such as certification of nurses in CPR, Pediatric Advanced Life Support, ventilator and tracheostomy care.
- Hold home medical equipment (HME) providers accountable to providing needed and proper functioning equipment and supplies.
- Require proof of family/parent training.
- Ensure communications and interdisciplinary meetings with all providers and the family (physician, therapists, care coordinator, nursing agencies, early intervention, schools, and other social service agencies).
- Require providers to conduct satisfaction surveys (eventually standardized) to measure access, quality and culturally sensitive and diverse care.

Performance measures for care coordination provided by CCEs/MCCNs for children with multiple chronic conditions not needing in-home services include the following:

Claims Data Outcomes

- Timeliness and rate of
 - Immunizations
 - Developmental Screenings
 - Mental Health Screenings
 - Obesity Screenings
 - Dental Care
 - Number of inpatient days
 - Number of visits in the Emergency Room
 - Percent of children with a physician visit within 7/14 days of discharge
 - Percent of children with a readmission within 7 days of discharge
 - Percent of procedures that are repeated
 - Drug redundancies/inconsistent prescription filling (Select a few sentinel medications to focus on)
 - Mean total payments

Process Outcomes

- Chart audits to determine completed referrals, family adherence, completion of plans of care and documentation of planning for transition to adult care.
- Parent Surveys to determine satisfaction with care coordination and access to services and providers

The group also recommended an Evaluation Committee inclusive of all the partners to guide and support the evaluation and quality assurance efforts of the solicitation for the Department's Innovations Project.

12. Next Steps

The Department will issue a solicitation for a CCE/MCCN to provide care coordination of children with multiple chronic conditions in the spring of 2012.

The Department will work with DSCC to develop a proposal for care coordination of children with technology needs seeking in home services through an intergovernmental agreement.

The Department will work with legislators on budget initiatives considering the renewal of the waiver, cost share and FPLs for children.

IV. INFORMATION SYSTEM IMPROVEMENTS

At the end of fiscal year 2011, consistent with terms of the Medicaid Reform Act, HFS was one of the agencies participating in the development a high-level information systems strategy that was submitted to the General Assembly. This section outlines the progress that HFS has made against four important information system elements for which it has lead responsibility.

1. Medicaid Management Information System Modernization

The Department initiated a planning effort in 2009 to replace its 30 year old legacy Medicaid Management Information System (MMIS). This is the core system that HFS uses to process all Medicaid claims, including managing provider relationships and claims to the Federal government. The existing MMIS was fully implemented in 1982 and was primarily built to support a fee-for-service Medicaid program. Throughout the years, HFS has made many enhancements and modifications to the current MMIS; however, it is an older legacy system that is becoming increasingly more difficult to maintain and modify and is out of touch with many of the contemporary needs for cost control in an increasingly care-coordinated environment.

HFS has committed that the new MMIS will be designed in accord with the Medicaid Information Technology Architecture (MITA) developed by federal Department of Health and Human Services (HHS) to increase coordination among states and allow for much greater use of component software. HFS has conducted a MITA state self-assessment (SSA) and determined that the current MMIS is at a very low level of MITA compliance and will need to make major improvements.

HFS will begin the MMIS replacement with the implementation of a Pharmacy Benefits Management System (PBMS). This is essential to improving the management of pharmacy claims, including allowing electronic prescribing and instituting greater utilization review of pharmaceutical usage. The Department has made significant progress on the crafting of the RFP and expects to release it to the public in spring 2012. Immediately following this release, HFS will finalize the RFP for the MMIS core system replacement with an expected release date in late fall 2012.

2. Enterprise Data Warehouse Upgrade

As anticipated in the strategic plan, a new contract for the Enterprise Data Warehouse (EDW) was executed at the end of 2011. The EDW is a repository of information extracted from the MMIS that allows for quick and timely analysis of Medicaid data without interfering with the production system. It was created in the late 1990's, and at that time was one of the most advanced uses of relational data bases in the state. The new EDW contract provides for a complete upgrade of the hardware currently in use. This increased capacity will provide much needed space and processing capability to meet the needs of the EDW as it becomes a more integrated tool for all the health care agencies in the state.

In addition, the contract adds the position of Metadata Coordinator to the EDW team on the vendor side. Metadata is the technical term for the description of data in a consistent way across all the applications in use. This update will provide for enhanced capture of valuable business rules and metadata as new data sources are added to the EDW, as well as clean-up and enhancement of metadata for existing data structures. While this may sound insignificant, management of data descriptions across the millions of data records in the MMIS and EDW is a major task and this upgrade in our capability will make the data materially easier to use, while at the same time increase consistency in report generation and interpretation.

New software is being provided under the new contract as well, including more robust analytical applications that allow for better coding of address information and for mechanisms that enable the system to keep multiple levels of report generation to correspond to changes in the data over time. A new web based version of the current report development software, Business Objects, along with Crystal Reports will be brought on board by the vendor to enhance the Department's reporting capabilities. An optional element that would provide department analysts enhanced capability to undertake risk analysis and improved quality of care assessments is also being considered.

In addition to changes in the hardware and software, HFS has recognized that the EDW needs active, strategic management to meet the rapidly evolving needs of its medical program management and state and federal requirements. As part of moving toward a more strategic use of the EDW environment, in September of 2011, HFS adopted an EDW vision focusing on the creation of a pro-active, professionally managed data environment that will: 1) enable Department leaders and other stakeholders to make informed decisions and satisfy mandates, and: 2) provide HFS EDW users and external data users, having a variety of skill levels, with consistent, reliable data and descriptive information in a format that is easily and effectively accessed, understood, and used.

3. State Medicaid Health Information Plan

HFS is also responsible for the development and implementation of federally mandated State Medicaid Health Information Plan (SMHP). In the last year, Illinois received approval of its SMHP from federal CMS and has begun implementing the initial phase of the plan. Among other things the plan establishes an Electronic Health Record (EHR) Provider Incentive Payment (PIP) Program, which provides federal subsidies to individual Medicaid providers for the installation of electronic health record (EHR) systems. The SMHP also assesses the current landscape of the state's EHR adoption and Health Information Exchange (HIE) development among Medicaid providers, the state's vision for Health Information Technology (HIT) in the year 2014 and specific actions to implement the state's vision. Finally, the SMHP addresses how the Department's efforts to promote EHR adoption and meaningful use by its providers will be part of a coordinated, broad-based initiative to promote system interoperability, EHR meaningful use and quality improvements, and health information exchange throughout Illinois' health care system.

The first payments under the EHR/PIP Program were made in March 2012 when HFS released \$24 million in incentive payments to Illinois Medicaid providers. This represents payments to more than 450 providers for the implementation of certified EHR technology. To date, HFS has received more than 2,000 attestations for the program, and expects the numbers to continue to grow. The Department estimates the 100 percent federally funded payments to eligible providers will be \$116 million the first year and \$489 million over the life of the program, which continues through 2021.

4. Replacement Eligibility System

In another critical area, HFS has been deeply involved with the Department of Human Services (DHS) and the Department of Insurance (DOI) to implement a new eligibility system, known as the Integrated Eligibility System (IES) will span Medicaid, Supplemental Nutrition Assistance Program (SNAP—formerly known as “food stamps”), Temporary Assistance for Needy Families (TANF—formerly known as “welfare” or perhaps AFDC) and the new Health Benefits Exchange that will be created as part of the federal *Affordable Care Act (ACA)*. This system will replace the

more than 30-year old, COBOL-based system that is at the core of current eligibility determinations for these services; except the Health Benefits Exchange, which did not previously exist. It is the existence of the ACA that has made it possible to fund the new IES, as it provides additional Medicaid funds and also suspends the usual rules of federal program cost allocation so that a much larger share of SNAP and TANF costs are covered under the enhanced Medicaid match. Work on the system must be completed by the end of 2015, at which time the enhanced federal match sunsets. Current estimates are that Illinois will receive more than \$100 million in federal dollars for this effort.

Developmental work on the IES started in the fall of 2010 and a high level strategic plan was developed in the spring of 2011. In September 2011, HHS approved the enhanced match for the development of an RFP for the project and in March, 2012, approved the match for implementation of the system, at which time the RFP was published. It is expected that a vendor will be selected by late summer. The state anticipates implementing the eligibility portion of IES for these programs by October 2013, and being ready to provide coverage for new applicants by January 2014. The remainder of the system, which focuses on account management, will be implemented in a second phase with an estimated completion date of October 1, 2015. Due to the short timeframe, the exact sequencing is uncertain and there may be other ways of structuring the phase in, such as, including some use of a federal-state partnership to help bridge. The state also intends to use this project as the basis for developing a common eligibility system that, within the State's Framework Project, could extend to other agencies.

V. 2011 HIGHLIGHTS

Integrated Care Program

HFS implemented the state's first integrated healthcare program on May 1, 2011. The Integrated Care Program (ICP) is a program for older adults, and adults with disabilities, who are eligible for Medicaid, but not eligible for Medicare. The program is mandatory and operates in the pilot areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. The ICP brings together local primary care physicians, specialist, hospital, nursing homes and other providers so that all care is organized around the needs of the client in order to achieve improvements in health through care coordination. As of July 1, 2011, approximately 12,350 clients had been enrolled in the ICP. Additional information on the ICP can be found in Section XII, Care Management, of this report.

Health Benefits/All Kids and Drug Prior Approval Hotline

As of June 30, 2011, the Health Benefits/All Kids and the Drug Prior Approval Hotlines had received and handled over 787,000 calls from enrollees and provider communities. The Drug Prior Approval/Refill Too Soon Hotline answered over 336,000 of the calls, reflecting an increase of approximately 14 percent over fiscal year 2010.

Money Follows the Person

Illinois was selected as a MFP Demonstration Program in 2007. In 2010, the Affordable Care Act extended the demonstration program through 2016. As the lead agency, HFS plans to continue participation in the program along with its sister agencies through the end of the demonstration.

Illinois' MFP program relies on a strong collaborative and inter-agency approach to the implementation of the program. The Department partners with the Department on Aging (DoA), Department of Human Services' (DHS) Division of Mental Health, Division of Rehabilitation Services, and Division of Developmental Disabilities, and the Illinois Housing Development Authority on the formation of policy and implementation issues related to MFP. HFS has provided the Department of Human Services' Division of Developmental Disabilities with the necessary support for their full participation in MFP, which began January 1, 2012. Another critical partner to the MFP Program is the University of Illinois at Chicago – College of Nursing, who oversees the programs quality management initiative and has authored significant work on "lessons learned" from the MFP program. The Department has utilized this work to guide the development and implementation of MFP program innovations.

Supportive Living Program

In 2011, under Illinois' assisted living waiver, which is considered to be the premier model of its kind in the country, the number of Supportive Living Facilities (SLFs) increased by six percent and the number of apartments available increased by four percent. As of June 30, 2011, 5,608 Medicaid eligible residents were being served by 128 SLFs, with a total of 9,967 apartments in operation. Throughout fiscal year 2011, over 8,600 unduplicated Medicaid enrollees were served under the program. The program combines affordable apartment-like housing, personal care and health related services in an assisted living setting for individuals who otherwise qualify for residency in a nursing facility. There are currently 31 more facilities in various stages of development. The Supportive Living Program is one of the nine Home and Community-Based Services (HCBS) waivers administered by the Department. For more information on the HCBS waivers, refer to Section IX, Home and Community Based-Services Waivers, of this report.

Provider Enrollment and Information

As of June 30, 2011, there were over 67,700 providers enrolled to provide services to participants of the Department's Medical Assistance Programs, as compared to approximately 62,000 enrolled as of June 30, 2010. For a breakout by major provider type, see Table IV of this report. Providers are encouraged to utilize the Department's Web site to obtain information on the Department's Medical Programs. The address for the Division of Medical Programs' main web page is:

<http://www.myhfs.illinois.gov/>

Claims Processing

During fiscal year 2011, ninety-one million medical claims were received and processed by the Department. This was an increase of 2.3 percent over the number of claims received in fiscal year 2010 and a 5.5 percent increase over claims received during fiscal year 2009.

Of all the claims received in fiscal year 2011, approximately eighty-seven million, or 96.2 percent, were received via electronic transfer, up slightly from 95.9 percent in fiscal year 2010. Table VI shows claims receipt history for fiscal years 2009 through 2011.

Pharmacy claims accounted for the largest share (46 percent) of total claims received during fiscal year 2011, with physician claims (33 percent), Medicare (8 percent), hospitals (6 percent), and claims for medical equipment/supply (3 percent) rounding out the top five receipt categories. Between fiscal years 2009 and 2011, the fastest growing claims category was pharmacy showing approximately a 20 percent increase, followed by medical equipment and supplies increasing by over 17 percent and hospital claims increasing by over 8 percent.

The Department's PrePay Pricing Unit is responsible for reviewing those medical claims that require specific review by professional medical staff to determine the appropriate reimbursement. During fiscal year 2011, the PrePay Pricing Unit reviewed requests for reimbursement for 7.2 million services, a decrease of 1.6 percent from the number of services reviewed in fiscal year 2010. In fiscal year 2011, the claim reviews performed by the PrePay Pricing Unit resulted in savings of approximately \$129.5 million.

VI. FINANCIAL OVERVIEW

The three tables presented at the end of this section provide a history of liability by estimated funding source for Medical Programs in HFS. It is important to take into account what is included in these tables and how they differ from other presentations.

The tables cover fiscal year 2010 to fiscal year 2012. The data is presented in a similar format so it is possible to observe trends.

The tables reflect HFS *liabilities*; meaning that all claims HFS has received and accepted through the assignment of a document control number is included. The data does not reflect date of service billings, as HFS receives claims in any given fiscal year for services that were provided in the previous fiscal year. In addition, the information presented in the tables does not include the impact of any annual payment cycle changes (i.e. potential underfunding), as the data simply reflects the estimated funding breakout for bills actually received by the Department.

Using liabilities as the unit for measure has the following advantages:

- HFS is legally liable for services provided. However, claims received are the only measure that it has to determine the liability incurred by the Department over a given time period.
- The flow of claims received is relatively consistent over time. The rate at which claims are submitted is not significantly influenced by the state's larger cash flow issues.
- The main reason the flow of claims may be different from one year to the next is the rate at which providers submit billings, and there is no reason to assume a systematic change in the speed with which this occurs.
- Because the data are fixed by the time frame of submission, it is possible to obtain information allowing for time-period comparisons quickly. Waiting to get actual liability (date of service claim data, including the "incurred but not reported" liability) would require a wait of twelve months, as providers have that long to submit a claim to the Department.

The tables include all funding sources, not just General Revenue Fund (GRF) expenditures. Since most action by the General Assembly focuses on GRF budgets, many HFS reports only reflect liability from funds that impact GRF spending. But, as reflected in the tables, there are significant non-GRF expenditures. It is difficult to understand the full magnitude of the State's Medical Assistance Program expenditures without including these funds.

The data only reflect funds spent within HFS. While *most* of the liability is Medicaid related and qualifies for federal matching dollars under *Title 19 or Title 21 (the Children's Health Insurance Reauthorization Act) of the Social Security Act*, some spending is for state-only funded medical programs.

It should also be noted that the tables do not include Medicaid Assistance expenditures made in the budgets of other departments and entities. These are material, amounting to roughly \$2 billion per year.

The data contained in the tables provides a high level snapshot of the Medical Assistance Program budget and, particularly, reflects the dynamic elements in the Medicaid program. A few of the important observations that can be made from these tables include the following:

- Total liability between fiscal year 2010 and fiscal year 2012 will increase just over 10 percent (or an average of about 5.1 percent per year). Note, however, this includes the costs associated with increased enrollment; over the same period enrollment will also increase by about 5.1 percent per year.
- The Medicaid program is jointly funded by the state, the federal government, local governments and provider assessments. For these three years, the share of total liability paid with state money varies by year, primarily as a function of the enhanced match rate that was part of *the American Recovery and Reinvestment Act (ARRA)*. For fiscal year 2011, the subject of this report, the estimated GRF liability funding is approximately one-fifth of total liability. With the expiration of the ARRA enhanced match, this share will rise considerably for fiscal year 2012, but will still be less than one-third of total liability.
- Revenue sources other than the usual sources of state-money or federal match are important. In fiscal year 2011, assessments on providers and intergovernmental funding arrangements, specifically structured to enhance federal match, accounted for a significant portion of total liability funding. These include the hospital provider assessment, long-term care provider assessment, and the Cook County and U of I intergovernmental transfers. How these funding sources are handled going forward is a crucial issue for the Medicaid program.

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

FY10 Estimated Liability Funding*

(\$ in Thousands)

	FY10 Liability	FY10 Estimated Net GRF	FY10 Estimated GRF Fed. Match	FY10 Gross Other Funds	FY10 Total Liability Funding*
PRACTITIONERS	\$1,246,588.8	\$394,048.7	\$584,781.9	\$267,758.2	\$1,246,588.8
Physicians	962,402.0	292,258.1	433,723.6	236,420.3	962,402.0
Dentists	233,730.2	85,589.8	127,016.1	21,124.3	233,730.2
Optometrists	41,766.0	13,441.6	19,947.5	8,376.9	41,766.0
Podiatrists	7,183.0	2,268.6	3,366.7	1,547.7	7,183.0
Chiropractors	1,507.6	490.6	728.0	289.0	1,507.6
HOSPITALS	\$3,300,718.0	\$858,395.8	\$1,273,833.6	\$1,168,488.6	\$3,300,718.0
PRESCR. DRUGS	\$1,794,360.6	\$327,900.0	\$486,783.1	\$979,677.5	\$1,794,360.6
LONG TERM CARE	\$1,793,010.0	\$319,938.0	\$474,793.9	\$998,278.1	\$1,793,010.0
Geriatric	1,538,010.0	231,011.5	342,826.2	964,172.3	1,538,010.0
Institutions for Mental Disease	138,205.0	49,121.1	72,896.1	16,187.8	138,205.0
Supportive Living Facilities	116,795.0	39,805.4	59,071.6	17,918.0	116,795.0
OTHER MEDICAL	\$1,294,350.3	\$442,709.0	\$656,984.3	\$194,657.0	\$1,294,350.3
Community Health Centers	297,683.0	101,353.2	150,409.2	45,920.6	297,683.0
Hospice	83,869.0	21,685.6	32,181.6	30,001.8	83,869.0
Laboratories	56,418.0	15,055.8	22,343.0	19,019.2	56,418.0
Home Health Care	85,036.0	26,559.3	38,836.3	19,640.4	85,036.0
DSCC Waiver	62,603.1	24,969.8	37,633.3	0.0	62,603.1
Appliances	87,808.0	23,932.9	35,516.6	28,358.5	87,808.0
Transportation	93,004.0	29,096.5	43,179.3	20,728.2	93,004.0
Other Related	189,743.2	63,910.7	94,844.2	30,988.3	189,743.2
Medicare A Premiums	19,513.0	7,855.4	11,657.6	0.0	19,513.0
Medicare B Premiums	297,192.0	119,642.1	177,549.9	0.0	297,192.0
Medicare B Premiums Expansion	21,481.0	8,647.7	12,833.3	0.0	21,481.0
MANAGED CARE	\$249,829.0	\$92,147.5	\$136,747.6	\$20,933.9	\$249,829.0
Child Health Rebate	6,485.9	2,611.1	3,874.8	0.0	6,485.9
Renal Dialysis Services	714.0	256.9	381.2	75.9	714.0
Hemophilia Services	13,725.5	5,525.5	8,200.0	0.0	13,725.5
Sexual Assault Treatment	1,653.7	665.7	988.0	0.0	1,653.7
HFS MEDICAL - GRF & RELATED FUNDS	\$9,701,435.8	\$2,444,198.2	\$3,627,368.4	\$3,629,869.2	\$9,701,435.8
Hospital Assessment	1,514,344.0	0.0	0.0	1,514,344.0	1,514,344.0
Cook County	1,383,249.3	0.0	0.0	1,383,249.3	1,383,249.3
University of Illinois Hospital	199,074.2	75,000.0	0.0	124,074.2	199,074.2
Other Payment Programs**	214,071.2	400.0	0.0	213,671.2	214,071.2
HFS MEDICAL - ALL FUNDS	\$13,012,174.5	\$2,519,598.2	\$3,627,368.4	\$6,865,207.9	\$13,012,174.5

* "FY10 Total Liability Funding" reflects one-year program costs for FY10; excludes unpaid bills from the prior year.

Spending figures on this page mainly reflect cash-flow expenditures and will not equal actuals for prior years due to the exclusion of the impact of prior and current year bills on hand.

** Other Payment Programs include Trauma Center payments, Excellence in Academic Medicine, Children's SASS and pass-through of federal matching dollars to local school districts and counties.

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
FY11 Estimated Liability Funding*

(\$ in Thousands)

	FY11 Liability	FY11 Estimated Net GRF	FY11 Estimated GRF Fed. Match	FY11 Gross Other Funds	FY11 Total Liability Funding*
PRACTITIONERS	\$1,339,350.0	\$511,063.9	\$654,418.3	\$173,867.8	\$1,339,350.0
Physicians	1,005,958.6	380,515.3	487,250.4	138,192.9	1,005,958.6
Dentists	276,721.7	110,269.6	141,200.5	25,251.6	276,721.7
Optometrists	47,234.0	16,918.1	21,663.7	8,652.2	47,234.0
Podiatrists	7,863.1	2,802.8	3,589.1	1,471.2	7,863.1
Chiropractors	1,572.6	558.1	714.6	299.9	1,572.6
HOSPITALS	\$3,457,049.0	\$1,063,309.7	\$1,361,569.9	\$1,032,169.4	\$3,457,049.0
PRESCR. DRUGS	\$2,021,544.6	\$275,548.0	\$352,839.7	\$1,393,156.9	\$2,021,544.6
LONG TERM CARE	\$1,911,919.6	\$414,491.3	\$530,756.8	\$966,671.5	\$1,911,919.6
Geriatric	1,654,626.3	307,694.8	394,003.8	952,927.7	1,654,626.3
Institutions for Mental Disease	110,529.1	46,855.4	59,998.5	3,675.2	110,529.1
Supportive Living Facilities	146,764.2	59,941.0	76,754.6	10,068.6	146,764.2
OTHER MEDICAL	\$1,424,836.1	\$544,503.2	\$697,237.3	\$183,095.6	\$1,424,836.1
Community Health Centers	334,750.5	116,910.3	149,703.9	68,136.3	334,750.5
Hospice	85,399.4	27,288.6	34,943.0	23,167.8	85,399.4
Laboratories	60,392.5	20,144.3	25,794.7	14,453.5	60,392.5
Home Health Care	94,715.3	33,715.1	43,172.3	17,827.9	94,715.3
DSCC Waiver	69,619.5	30,528.2	39,091.3	0.0	69,619.5
Appliances	96,153.1	33,334.0	42,684.3	20,134.8	96,153.1
Transportation	87,819.7	31,249.2	40,014.6	16,555.9	87,819.7
Other Related	205,054.6	79,910.1	102,325.1	22,819.4	205,054.6
Medicare A Premiums	18,288.6	8,019.6	10,269.0	0.0	18,288.6
Medicare B Premiums	349,130.2	153,093.6	196,036.6	0.0	349,130.2
Medicare B Premiums Expansion	23,512.7	10,310.3	13,202.4	0.0	23,512.7
MANAGED CARE	\$246,719.4	\$107,082.3	\$137,119.0	\$2,518.1	\$246,719.4
Child Health Rebate	6,834.1	2,996.8	3,837.3	0.0	6,834.1
Renal Dialysis Services	461.0	165.4	211.8	83.8	461.0
Hemophilia Services	17,784.4	7,798.5	9,985.9	0.0	17,784.4
Sexual Assault Treatment	2,276.7	998.3	1,278.4	0.0	2,276.7
HFS MEDICAL - GRF & RELATED FUNDS	\$10,428,774.9	\$2,927,957.4	\$3,749,254.4	\$3,751,563.1	\$10,428,774.9
Hospital Assessment	1,510,668.0	0.0	0.0	1,510,668.0	1,510,668.0
Cook County	1,349,708.2	0.0	0.0	1,349,708.2	1,349,708.2
University of Illinois Hospital	269,290.3	99,054.0	0.0	170,236.3	269,290.3
Other Payment Programs**	264,346.8	400.0	0.0	263,946.8	264,346.8
HFS MEDICAL - ALL FUNDS	\$13,822,788.2	\$3,027,411.4	\$3,749,254.4	\$7,046,122.4	\$13,822,788.2

* "FY11 Total Liability Funding" reflects one-year program costs for FY11; excludes unpaid bills from the prior year.

Spending figures on this page mainly reflect cash-flow expenditures and will not equal actuals for prior years due to the exclusion of the impact of prior and current year bills on hand.

** Other Payment Programs include Trauma Center payments, Excellence in Academic Medicine, Children's SASS and pass-through of federal matching dollars to local school districts and counties.

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
FY'12 Estimated Liability Funding*

(\$ in Thousands)

	FY12 Estimated Liability	FY12 Estimated Net GRF	FY12 Estimated GRF Fed. Match	FY12 Gross Other Funds	FY12 Total Liability Funding*
PRACTITIONERS	\$1,336,558.0	\$637,336.7	\$603,825.3	\$95,396.0	\$1,336,558.0
Physicians	988,158.0	458,433.3	434,328.7	95,396.0	988,158.0
Dentists	287,754.2	147,761.8	139,992.4	0.0	287,754.2
Optometrists	51,482.4	26,436.2	25,046.2	0.0	51,482.4
Podiatrists	7,636.7	3,921.4	3,715.3	0.0	7,636.7
Chiropractors	1,526.7	784.0	742.7	0.0	1,526.7
HOSPITALS	\$3,205,048.7	\$1,496,364.0	\$1,417,684.7	\$291,000.0	\$3,205,048.7
PRESCR. DRUGS	\$2,166,576.6	\$701,158.2	\$664,291.1	\$801,127.3	\$2,166,576.6
LONG TERM CARE	\$1,939,336.3	\$693,350.6	\$656,893.9	\$589,091.8	\$1,939,336.3
Geriatric	1,654,798.8	557,478.1	528,165.7	569,155.0	1,654,798.8
Institutions for Mental Disease	128,539.5	66,005.0	62,534.5	0.0	128,539.5
Supportive Living Facilities	155,998.0	69,867.4	66,193.8	19,936.8	155,998.0
OTHER MEDICAL	\$1,447,537.2	\$732,469.0	\$693,955.6	\$21,112.6	\$1,447,537.2
Community Health Centers	348,884.8	179,152.3	169,732.5	0.0	348,884.8
Hospice	91,768.5	47,123.1	44,645.4	0.0	91,768.5
Laboratories	54,895.4	28,188.8	26,706.6	0.0	54,895.4
Home Health Care	103,315.6	53,052.6	50,263.0	0.0	103,315.6
DSCC Waiver	67,770.5	34,800.2	32,970.3	0.0	67,770.5
Appliances	87,604.2	44,984.8	42,619.4	0.0	87,604.2
Transportation	71,167.8	36,544.7	34,623.1	0.0	71,167.8
Other Related	199,066.0	91,379.1	86,574.3	21,112.6	199,066.0
Medicare A Premiums	17,095.3	8,778.4	8,316.9	0.0	17,095.3
Medicare B Premiums	379,497.3	194,871.9	184,625.4	0.0	379,497.3
Medicare B Premiums Expansion	26,471.8	13,593.3	12,878.5	0.0	26,471.8
MANAGED CARE	\$744,038.2	\$160,337.7	\$151,907.0	\$431,793.5	\$744,038.2
Child Health Rebate	9,007.9	3,900.1	3,695.0	1,412.8	9,007.9
Renal Dialysis Services	462.0	237.2	224.8	0.0	462.0
Hemophilia Services	18,375.7	8,705.0	8,247.2	1,423.5	18,375.7
Sexual Assault Treatment	2,310.3	1,186.3	1,124.0	0.0	2,310.3
HFS MEDICAL - GRF & RELATED FUNDS	\$10,869,250.9	\$4,435,044.8	\$4,201,848.6	\$2,232,357.5	\$10,869,250.9
Hospital Assessment	1,507,310.8	0.0	0.0	1,507,310.8	1,507,310.8
Cook County	1,419,576.3	0.0	0.0	1,419,576.3	1,419,576.3
University of Illinois Hospital	238,347.3	90,000.0	0.0	148,347.3	238,347.3
Other Payment Programs**	282,975.0	14,175.0	0.0	268,800.0	282,975.0
HFS MEDICAL - ALL FUNDS	\$14,317,460.3	\$4,539,219.8	\$4,201,848.6	\$5,576,391.9	\$14,317,460.3

* "FY12 Total Liability Funding" reflects one-year program costs for FY12; excludes unpaid bills from the prior year.

Spending figures on this page mainly reflect cash-flow expenditures and will not equal actuals for prior years due to the exclusion of the impact of prior and current year bills on hand.

** Other Payment Programs include Trauma Center payments, Excellence in Academic Medicine, Children's SASS and pass-through of federal matching dollars to local school districts and counties.

VII. MONEY FOLLOWS THE PERSON – FISCAL YEAR 2011 ANNUAL REPORT

In 2010, the Affordable Care Act extended the Federal Money Follows the Person (MFP) Demonstration Program through 2016. Illinois was selected as a MFP Demonstration Program in 2007. The Department plans to continue participation in the program along with our sister agencies through the end of the demonstration.

The MFP program consists of two parts: a transition component to identify Medicaid beneficiaries living in institutions who wish to live in the community and provide them with the supports to do so, and a rebalancing component through which participating states make system changes that promote and enhance the provision of community-based services and supports.

Illinois' MFP program relies on a strong collaborative and inter-agency approach to the implementation of the program. The Department partners with the Department on Aging (DoA), Department of Human Services' (DHS) Division of Mental Health, Division of Rehabilitation Services, and Division of Developmental Disabilities, and the Illinois Housing Development Authority on the formation of policy and implementation issues related to MFP. HFS has provided the Department of Human Services' Division of Developmental Disabilities with the necessary support for their full participation in MFP, which began January 1, 2012. Another critical partner to the MFP Program is the University of Illinois at Chicago – College of Nursing, who oversees the programs quality management initiative and has authored significant work on “lessons learned” from the MFP program. The Department has utilized this work to guide the development and implementation of MFP program innovations.

In fiscal year 2011, the Federal Centers for Medicare and Medicaid Services provided States with a supplemental funding opportunity to improve the collaboration between the MFP Program and the Aging and Disability Resource Centers (ADRC). The Department was notified that its grant proposal was awarded the full amount that was requested. With this additional \$400,000 grant, the Department, in collaboration with DoA, selected three ADRC's – Age Options, Northeastern Illinois Area on Aging, and Central Illinois Area on Aging to pilot a coordinated, cross disability approach to outreach and engagement of potential MFP participants. Increased transition numbers for the three selected pilot sites is an expectation under the two year grant.

States are required to reinvest rebalancing funds back into the community system of services and supports. The rebalancing funds are the net federal revenues, above the regular Federal Medicaid Assistance Percentage (FMAP), from the enhanced FMAP match rate that states receive for expenditures on Qualified and Demonstration Home and Community Based services provided to MFP participants during their first 365 days of community living.

Using a combination of MFP rebalancing funds and administrative claiming, the Department, along with DHS Division of Mental Health, has selected three areas of the state – Peoria, Springfield and DuPage Counties – for expansion of mental health services under MFP. Selection of these areas was based on their capacity to provide Assertive Community Treatment (ACT) and the nursing home populations necessary to provide an adequate supply of potential MFP enrollees. Increased MFP transitions are an expectation for these three areas.

The Department, in collaboration with our state agency partners and stakeholders, is in the process of updating the MFP marketing and outreach materials. This marketing and outreach initiative includes: the development of a MFP participant packet to be distributed to nursing homes, ombudsman, and other potential referral sources; the activation of the MFP website; and the development of a MFP self-referral form.

During calendar year (CY) 2011, the MFP Program completed a total of 237 successful transitions, an increase of 53 transitions over the CY 2010 total. The Department anticipates growth in the number of transitions for CY 2012 due to a number of factors including: the settlement of two Olmstead related class action lawsuits – Ligas v. Quinn and Colbert v. Quinn; the Administration's Long Term Care Rebalancing Initiative; the MFP/ADRC collaboration; the expansion of MFP/mental health downstate; and the full participation of DHS Division of Developmental Disabilities in MFP.

Calendar Year 2011 Transitions

Agency/Division	# Transitions
Illinois Department on Aging	75
Illinois Department of Human Services – Division of Rehabilitation Services	67
Illinois Department of Human Services – Division of Mental Health	95
Total:	237

State Medicaid long-term care expenditures and the percentage of such expenditures devoted to community-based long-term care services are summarized in the table below.

Long Term Care (LTC)/Home and Community Based Service (HCBS) Expenditures

State Fiscal Year	Total LTC Expenditures	Total HCBS Expenditures	% of Expenditures for HCBS Services
2009	\$4,183,134,560	\$1,768,588,092	42.28%
2010	\$3,480,969,534	\$1,147,859,338	32.98%
2011	\$3,796,676,636	\$1,473,153,616	38.80%

VIII. LONG TERM CARE

In fiscal year 2011, the monthly average of people served in nursing facilities (NFs) remained at approximately 55,000, the same level as in the past several years. The number of nursing facilities serving these people decreased slightly, going from 738 in 2010 to 734 in 2011 (refer to Certification/Decertification topic below for more detail).

Table I, in Section XXV, compares Medicaid certified beds versus licensed beds in NFs and Table II shows long-term care total charges and liability on claims received for fiscal years 2009 through 2011. In an effort to provide alternatives to NF placement, the Department also offered care through nine Home and Community-Based Services (HCBS) waiver programs which served almost 90,000 people. For more information on the HCBS waivers refer to Section IX, Appendix B and Table VII.

Field Activity

The Department continues to use long term care field staff, consisting of registered nurses and medical assistance consultants, to provide facilities with oversight and technical assistance to ensure services provided to residents are appropriate to meet their individual needs and in compliance with state and federal rules. Tasks performed by field staff include: developing and implementing field processes for certification and ongoing monitoring of Supported Living Facilities (SLFs), including investigations of complaints received through the SLF Complaint Hotline; conducting rate review protocols and methodologies, and; completing post-payment audits in NFs to ensure that claims for bed holds are appropriately billed.

Certification/Decertification

During fiscal year 2011, six nursing facilities (NF) and three Intermediate Care Facility for Developmental Disabilities (ICF/DD) closed. Of these facilities, one NF and one ICF/DD were terminated from participating in the Medicare and Medicaid Programs and all residents were relocated to appropriate settings. The remaining seven facilities closed voluntarily. During this same period, four new ICF/DDs were enrolled in the Medical Assistance Program.

MDS-Based Reimbursement Rate System

The Resident Assessment Instrument, commonly referred to as the MDS, is a federally mandated standardized resident assessment, care planning and quality monitoring system that drives care delivery in nursing facilities (NFs). The MDS is the foundation for the federal certification of resident care standards and requirements that the Department of Public Health (DPH) is responsible for enforcing in all Medicaid and/or Medicare certified nursing homes in Illinois. In administering this responsibility, DPH ensures compliance with the MDS program and enforces any sanctions as part of the licensure process.

All Medicare and Medicaid certified nursing facilities are required to complete the MDS on all residents and submit the data to the Department. The Department houses the MDS Data Repository, which is shared with the federal government. The MDS is used to classify residents into the Resource Utilization Groups that are used to calculate Medicare rates. The Department utilizes the MDS-based reimbursement as the rate-setting tool for the nursing component of the Medicaid NF payment.

Effective October 1, 2010, a new version of the MDS Assessment Data was implemented which contained new assessment information. During Calendar Year 2010, the MDS Data Repository stored 3,145,283 NF resident assessments. The system received and processed 179,325 new records, including admissions, quarterly

updates, change of status, and discharge records, for 165,234 unique individuals over the course of the reporting period. The Department monitors the accuracy of the MDS data to ensure correct coding and documentation of services provided by nursing facilities. Since August of 2008, the Department has performed 269 reviews on NF 5,977 residents MDS records; resulting in 215 rate reductions, 3 rate increases and 42 requiring no changes.

IX. HOME AND COMMUNITY BASED-SERVICES (HCBS) WAIVERS

Home and Community-Based Services (HCBS) waivers, authorized under 1915(c) of the Social Security Act, allow the State to provide specialized long-term care services in an individual's home or community. The 1915c waivers were initiated by the federal Centers for Medicare and Medicaid Services (CMS) in 1981. Illinois' first HCBS waiver programs began in 1983. The waiver programs allow individuals to remain in their homes or community rather than an institution. HCBS waivers must be cost-effective in comparison to institutions and approved by the federal CMS. The waivers are time-limited programs that are under continuous review by federal CMS. States have the discretion to design the waivers as they choose, within certain parameters. For example, State's may choose the number of consumers to serve, the services provided, whether or not the program is statewide, and whether to waive parental income for children.

In Illinois there are nine HCBS waivers. All but one waiver is operated by another state agency. This means that HFS has delegated the responsibility for day-to-day operations to the waiver operating agency. The Department directly administers the Supportive Living Program. For the other eight, the Department, in its role as the single state Medicaid agency, provides direction, oversight, program monitoring, fiscal monitoring, and administrative coordination to secure federal funding.

The programs operated by sister agencies include the HCBS waivers for: 1) Persons with HIV/AIDS, 2) Persons with Brain Injury, 3) Persons with Physical Disabilities, 4) Adults with Developmental Disabilities Waiver, 5) Children and Young Adults with Developmental Disabilities-Support Waiver, 6) Children and Young Adults with Developmental Disabilities-Residential Waiver, all of which are operated by the Department of Human Services; 7) Persons who are Elderly Waiver, operated by the Department on Aging, and; 8) Medically Fragile Technology Dependent (MFTD) Children Waiver, case managed by the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC). The roles and responsibilities of HFS and the other state agencies in the administration of the waivers are outlined in interagency agreements. In federal fiscal year 2011, 89,439 persons were served in HCBS waivers. The growth history of the waiver program from 2006 through 2010 is shown in the chart below.

Waiver Recipients and Expenditures		
Waiver Year (WY)	Unduplicated Served	Waiver Expenditures
WY 2006 LAG	71,316	\$836,277,918
WY 2007 LAG	70,621	\$877,816,914
WY 2008 LAG	80,202	\$1,038,667,293
WY 2009 LAG	84,685	\$1,138,724,311
WY 2010 Init	89,192	\$1,270,314,002

Note: Information is based on HCFA 372 Reports generated by the Department's Bureau of Program and Reimbursement Analysis (BPRA) on a point in time for the previous waiver year, which varies waiver by waiver. The HCFA 372 data will differ from information reported on a state fiscal year basis and from federal quarterly claiming reports via the CMS 64. Initial reports are not final.

Fiscal year 2011 was full of activity for HCBS waivers in Illinois. Three of the nine waivers were prepared for renewal; medically fragile and technology dependent, brain injury and adults with developmental disabilities (DD). HFS and the operating agencies worked extensively with the National Quality Enterprise, a federal CMS contractor, to design quality improvement systems, including the addition of new performance measures and for each of the waivers. For additional information on the HCBS waivers, please refer to Appendix B and Table VII of this report.

X. MATERNAL AND CHILD HEALTH PROMOTION

Improving the health outcomes of maternal and child beneficiaries continues to be one of the Department's highest priorities. The Department has a particular focus on preventive maternal and child health services and partners with other state agencies, advocacy groups, private funders, provider organizations, academia, and interested parties to achieve maternal and child health goals. Through these efforts, the Department implements initiatives designed to improve the health status of mothers, women, and children.

Improving Birth Outcomes

The Department covers about half of all Illinois births and over 90 percent of all births to teens in Illinois. Birth outcome data are summarized below:

- The low birth weight rate (<2,500 grams) for HFS covered births is slightly higher than the state rate (8.9 percent and 8.2 percent, respectively, calendar year (CY) 2009 HFS Enterprise Data Warehouse, Birth File Match).
- The Department's very low birth weight rate (<1,500 grams) is the same as the state rate (at 1.5 percent, CY 2009, HFS Enterprise Data Warehouse, Birth File Match). While very low birth weight represented less than 2 percent of all Medicaid-covered births, it accounts for almost 60 percent of the average costs of births (prenatal, delivery, postpartum, and first year of life).
- The number of births to Illinois teens (less than 20 years of age) has declined annually since 2009. However, the percentage of teen births covered by Medicaid has increased from 91.4 percent in 2007 to 93.6 percent in 2009. In 2001, the percentage of teen births covered by Medicaid was 80.3 percent. The following chart shows the annual number and percentage of Illinois teen births covered by Medicaid for fiscal years 2007 through 2009. 2009 is the most recent year of certified Birth Records from the Department of Public Health.

Annual Number and Percentage of Illinois Teen* Births Covered by Medicaid			
Year	# HFS Teen Births	# Illinois Teen Births	% Teen Births Covered by HFS
2007	16,399	17,944	91.4%
2008	16,010	17,266	92.7%
2009	14,994	16,003	93.6%

*Less than 20 years of age

Source: HFS Enterprise Data Warehouse, January 2011, Birth File Match

To improve birth outcomes, the Department is monitoring (tracking and trending) and identifying strategies for program implementation, such as: planned pregnancies/family planning, timely and risk-appropriate prenatal and postpartum care using evidence-based strategies; expanding birth intervals; access to smoking cessation; and behavioral health services, as needed. Prenatal and postpartum care data are summarized below and while further improvement is needed, a positive trend is being realized:

- The HFS unintended pregnancy rate was 66 percent in 2003, but after the implementation of Illinois Healthy Women (IHW), a downward trend has been experienced with a rate of 59.6 percent in 2009.
- Just over one-half of HFS women with full benefits receive family planning services.

- During the first six years of IHW, the percentage of women with interpregnancy intervals of greater than 24 months increased 1.2 percentage points.
- The percentage of HFS covered women who received timely prenatal care increased from 53.6 percent in 2008 to 55.5 percent in 2010.
- The number of perinatal depression screenings has continued to increase from 2009 to 2010. Women who received only prenatal screenings increased from 31 percent to 33 percent; women who received only postpartum screenings increased from 26 percent to 28 percent; and women who received both prenatal and postpartum depression screenings increased from 17 percent to 19 percent.
- The percentage of HFS covered women diagnosed with depression is substantially higher than non-HFS covered women (11.2 percent and 6.6 percent respectively in 2009). To address this issue, a provider training/engagement initiative on treating perinatal depression continues.
- During calendar year 2008 and 2009 among women enrolled in HFS nine months pre- and post-delivery who experienced an adverse birth outcome, as defined by low birth weight, very low birth weight, or infant death within the first year of life), nearly 97 percent of these women had one or more pre-existing conditions.

The data above illustrates the need for continued focus on improving birth outcomes. HFS continues to work on developing and implementing strategies to address these findings. Pursuant to *P. A. 93-0536*, the Department reports on the status of prenatal and perinatal healthcare services to the legislature every two years. The January 2012 Perinatal Report can be found in its entirety at:

<http://www.hfs.illinois.gov/mch/report.html>

Several of the Department's maternal and child health initiatives are described below.

Perinatal Depression Initiative

Perinatal depression encompasses a wide range of mood disorders that can affect a woman during pregnancy and after the birth of her child. If untreated perinatal depression adversely affects a mother's health and mental well-being, may cause pregnancy complications, impact adversely on birth weight, may lead to infant mortality and poor parent/infant bonding, and have a negative impact on infant development. Perinatal depression is under-recognized and under-treated.

Since December of 2004, the Department has operated a comprehensive perinatal depression initiative, funded by private grants and federal financial participation, as allowed, as well as reimbursement for perinatal depression risk assessment as a covered service. The initiative includes, but is not limited to, the following: provider consultation services; provider education services, including a perinatal antidepressant medications chart and free primary care provider training; a statewide 24-hour crisis hotline available for eligible women experiencing perinatal depression, including referral resource assistance; training of the mental health community to identify and treat mental disorders in pregnant and postpartum women; and collaborative efforts with DHS (Lead agency), advocates and other state agencies to implement Public Act 95-0469, Perinatal Mental Health Disorders Prevention and Treatment Act. As part of the initiative, the Department has a grant agreement with the University of Illinois at Chicago partner to operate a mental health consultation service for physicians serving the Medicaid population on perinatal depression.

Smoking Cessation

The Department continues to partner with the Department of Public Health, Department of Human Services and the American Lung Association to promote smoking cessation and use of the Illinois Tobacco Quitline for free confidential counseling services for tobacco users in an effort to improve birth outcomes. The Department provides reimbursement of pharmacological smoking cessation products to assist eligible pregnant and post-partum women, and other eligible persons in quitting smoking. Provider education to encourage referrals to the Illinois Tobacco Quitline is also a component of the program. Smoking cessation education and outreach efforts are contractually required to be performed for HFS members by the managed care organizations. Annually, a notice is sent to beneficiaries regarding the Illinois Tobacco Quitline.

Planned Pregnancies – Illinois Healthy Women (IHW)

The IHW program was implemented in April 2004 and was renewed for a three-year period ending March 2012. In September 2011, the Department submitted a renewal application to the Centers for Medicare and Medicaid Services (CMS) requesting to extend IHW for an additional three-year period or the maximum allowed. CMS has granted a 30-day extension on the waiver through April 30, 2012, while the renewal application is processed.

The federal demonstration waiver is designed to improve women's health and birth outcomes by expanding access to, and coverage of, publicly funded family planning services. Services, procedures and/or supplies provided for the purpose of family planning, such as, contraceptive initiation or management, which are performed during a family planning visit are claimed at the 90 percent Enhanced Federal Financial Participation (FFP) rate. Family planning related services performed as part of, or as follow-up to a family planning visit, such as services provided to identify or diagnose a family planning-related problem are billed at the Federal Medical Assistance Percentages (FMAP) rate. Screening mammograms and folic acid supplements are paid with State funds.

Since the inception of IHW through June 30, 2011, a total of 132,603 unduplicated women received services, reflecting an increase of over 25,000 women from June 30, 2010. During waiver year 7, the average cost for a woman receiving a year of family planning services was approximately \$350, while the average cost for prenatal care, delivery, postpartum care and the first year of the child's life was approximately \$11,900. Using the Guttmacher Institute's methodology, during the first seven years of the waiver, it is estimated that 19,193 births were averted due to the increased availability and utilization of family planning services through IHW. This resulted in an estimated net cost savings of approximately \$153.4 million for those seven years. In addition to cost savings, IHW evaluation findings include the following successes:

- During the first seven years of the waiver, IHW reached its target population. Approximately 57 percent of the women who applied for IHW were ages 19 through 24, and 75 percent had never been pregnant;
- About 80 percent of the women who enrolled in IHW utilized family planning services;
- The fertility rate of women enrolled in IHW remained below 2.5 percent from 2005 through 2009, compared to 10.6 percent in 2009 for women in the general population with incomes less than 200 percent of poverty, and;
- Unintended pregnancies continued to show a downward trend throughout the first six years of the waiver.

HFS collaborates with the DHS Family Planning program to improve outreach efforts with statewide community partners and providers to increase enrollment in IHW and to address provider training needs to ensure evidence-based family planning practices are being utilized and to improve billing submissions. Additional information on IHW can be found on the Department's Web site at:

www.illinoishealthywomen.com

Partnerships with Local Health Departments (LHD)

Through agreements with 74 local health departments (LHD) the Department continues to maximize available resources, to the extent allowed by the Department's State Plan, federal and state law, by assessing and processing data on expenditures incurred by the LHDs in excess of state payments made to them for eligible covered services rendered to Medicaid participants, in order to obtain federal reimbursement for allowable administrative expenses. This process brings in additional federal funds through the federal claiming process, which are passed to the LHD partners, to provide resources for further expansion of services and increased access for Medicaid participants for such services as, but not limited to, maternal and child preventive health and dental care.

Public-Private Partnerships

The Department continues to partner with a number of private foundations to fund pilot- initiatives designed to improve health outcomes and to provide assistance to Medicaid-enrolled providers in complying with new guidelines in the Patient Protection and Affordable Care Act. The private funds are leveraged with federal matching funds, as appropriate. The ultimate goal in piloting initiatives is to determine their effectiveness and to spread them on a statewide basis with ongoing state funds. Initiatives currently funded through public-private partnerships include the following projects: Bright Smiles from Birth (Fluoride Varnish Application); the development, testing and validation of a preconception risk assessment tool; Enhancing Developmentally Oriented Primary Care; Bright Futures as a Standard of Care; Assuring Better Child Health and Development III; and Promoting Health: Improving Quality in Obesity Care.

Healthy Kids

The federally required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is the nation's largest preventive child health initiative. The initiative is named "Healthy Kids" in Illinois. Under EPSDT, the Department provides initial and periodic examinations and medically necessary follow-up care to enrolled individuals younger than 21. Children receive preventive health screenings (including immunizations, developmental screening, lead screening and risk assessment) vision and hearing screening, and dental care. In 2010, the federal government passed the *Patient Protection and Affordable Care Act (ACA)* to provide health coverage to all Americans. One of the earliest provisions to take effect is Section 2713, which requires preventive care services to be provided as outlined in Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Bright Futures' goal is to improve the quality of health care services for children through health promotion, disease prevention, and applying evidence-endorsed guidelines in primary care practices serving the population under age 21. HFS entered into an agreement with the Illinois Chapter, American Academy of Pediatrics (ICAAP) to assist HFS in promoting Bright Futures including: Developing infrastructure and materials to promote Bright Futures in Illinois to HFS Primary Care Providers (PCPs, also referred to as "medical homes"), increasing awareness of Bright Futures guidelines among Illinois PCPs, and increasing consumer awareness of Bright Futures as a standard of care.

Measuring Progress

The Department monitors key indicators to gauge improvements in preventive healthcare utilization for children. Illinois uses indicators based on the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) or HEDIS-like indicators, to measure and trend performance in key areas of child health. These measures include, but are not limited to: Well Child Visits in the first 15 months of life; Well Child Visits at ages 3, 4, 5, and 6; Objective Developmental Screening; Objective Vision Screening; Childhood Immunization Status; Childhood Lead Screening Status; EPSDT Preventive Services Participation Rate, and; Dental Services Participation Rate of Individuals up to 21 years of age. Several of the child health measures are highlighted below, and provide baseline information to be used in monitoring and tracking improvements.

Well Child Visits in the First 15 Months of Life. The Department's experience in this measure, based on an administrative claims data calculation, for continuously enrolled recipients is shown in the chart below.

Well Child Visits in the First 15 months of Life: Continuously Enrolled			
Description	Calendar Year 2008	Calendar Year 2009	Calendar Year 2010
15 month olds with 6 or more well child visits	56.9%	58.7%	60.3%
15 month olds with no well child visits	4.2%	4.0%	4.1%

Source HFS Executive Information System, Data as of December 2011

Well Child Visits at ages 3, 4, 5 and 6. This HEDIS measure calculates the percentage of children from one to three years of age who had at least one objective developmental screening (ODS) before the target birth date. These data show that annually, across each age category, the rate of objective developmental screening has increased.

Well Child Visits at 3, 4, 5, and 6 Years of Life: Continuously Enrolled						
Calendar Year	Measure	3 Yrs.	4 Yrs.	5 Yrs.	6 Yrs.	Total
2008	Eligible Population	85,446	80,722	77,769	74,542	318,479
	Population # with at least 1 WCV	55,711	54,968	56,413	37,677	204,769
	Population % with at least 1 WCV	65.2%	68.1%	72.5%	50.5%	64.3%
2009	Eligible Population	96,444	88,117	84,073	81,448	350,082
	Population # with at least 1 WCV	63,311	60,321	61,394	43,313	228,339
	Population % with at least 1 WCV	65.6%	68.5%	73.0%	53.2%	65.2%
2010	Eligible Population	101,579	99,306	90,892	87,168	378,945
	Population # with at least 1 WCV	67,285	65,965	65,721	46,589	245,560
	Population % with at least 1 WCV	66.2%	66.4%	72.3%	53.4%	64.8%

Source: HFS Executive Information System, Data as of December 2011.

Objective Developmental Screening. This HEDIS measure calculates the percentage of children from one to three years of age who had at least one objective developmental screening (ODS) before the target birth date. These data show that annually, across each age category, the rate of objective developmental screenings has increased.

Objective Developmental Screening at 1, 2 and 3 Years of Age: Continuously Enrolled					
Calendar Year	Measure	1 Yr	2 Yrs	3 Yrs	Total
2008	Eligible Population	95,140	92,888	84,486	272,514
	Population # with at least 1 ODS	37,405	25,718	17,248	80,371
	Population % with at least 1 ODS	39.3%	27.7%	20.4%	29.5%
2009	Eligible Population	93,899	97,197	94,911	286,007
	Population # with at least 1 ODS	44,323	34,584	23,753	102,660
	Population % with at least 1 ODS	47.2%	35.6%	25.0%	35.9%
2010	Eligible Population	94,129	96,389	100,543	291,061
	Population # with at least 1 ODS	52,311	42,810	31,962	127,083
	Population % with at least 1 ODS	55.6%	44.4%	31.8%	43.7%

Source: HFS Executive Information System, Data as of December 2011

Childhood Immunization Status. The Department calculates immunization status of children at 36 months of age. The percentage of children immunized over the past three years is reflected in the table below.

Immunization Status* at 36 Months of Age: Continuously Enrolled			
Calendar Year	Measure	Title XIX	All Population
2008	Eligible Population	79,642	83,239
	Population Fully Immunized	56,922	59,435
	Fully Immunized %	71.5%	71.4%
2009	Eligible Population	86,943	90,490
	Population Fully Immunized	62,986	65,546
	Fully Immunized %	72.4%	72.4%
2010	Eligible Population	92,496	96,157
	Population Fully Immunized	67,292	69,859
	Fully Immunized %	72.8%	72.7%

* Combo 1: (4) DTaP; (3) IPV; (1) MMR; (3) Hib; (2) Hep B [(4-3-1-3-2)]

Source: HFS Executive Information System, December 2011

EPSDT Participation Rate. The Department calculates the EPSDT Participation Rate using the methodology prescribed by the Centers for Medicare & Medicaid Services (CMS), based on the CMS 416 report guidelines. The EPSDT participation rate for the Title XIX (Medicaid) population and for **all enrolled** children under 21 years of age has continued to increase from federal fiscal year 2005 through 2009, even as the number of children enrolled substantially increased—resulting in more required EPSDT (well child) visits.

Illinois EPSDT Participation Rate*				
Federal Fiscal Year	Title XIX (Medicaid) EPSDT Participation Ratio	Number of Title XIX (Medicaid) Enrolled Children Under 21	All Population EPSDT Participation Ratio	Number of All Enrolled Children Under 21
2005	67.1%	1,272,938	67.8%	1,335,597
2006	68.2%	1,336,033	69.0%	1,433,163
2007	69.2%	1,392,361	70.3%	1,539,388
2008	67.0%	1,472,021	68.0%	1,631,532
2009	74.0%	1,561,906	74.9%	1,730,691
	Title XIX (Medicaid) and Title XXI (CHIP) EPSDT Participation Ratio	Number of Title XIX (Medicaid) or Title XXI (CHIP) Enrolled Children Under 21	All Population EPSDT Participation Ratio	Number of All Enrolled Children Under 21
2010**	75.0%	1,630,605	76.3%	1,803,823

Source: Illinois CMS-416 Report

*uses an adjusted rate methodology, based on CMS-416 methodology

** Beginning FFY2010, CMS-416 reporting guidance was revised by the Centers for Medicare and Medicaid Services (CMS) to reflect changes in the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA), and to include recommendations from CMS, states and external partners to improve the data reported.

Improving the Quality of Children's Health Care

The *Children's Health Insurance Program Reauthorization Act (CHIPRA)* was signed into law on February 4, 2009. *Title IV of CHIPRA* creates a broad quality mandate for children's health care and authorizes health care quality initiatives for both the Children's Health Insurance Program (CHIP) and the Medicaid program. CHIPRA seeks to improve access to and the quality of health care provided to children. As authorized in *Section 401(d) of CHIPRA*, in February 2010 the Centers for Medicare & Medicaid Services (CMS) awarded one of ten CHIPRA Quality Demonstration Grant funds to Florida as the lead state and Illinois as the partnering state.

The grant was awarded for a five-year period beginning in February 2010 and continuing to February 2015. The first grant year was devoted to planning and development of an operational work plan. Implementation of grant activities began in Year 2, starting February 2011. In accordance with the terms and conditions of the CHIPRA grant and the work plan developed with stakeholder input, in 2011, HFS began working to test, implement, operationalize, and integrate interventions to improve the quality of children's health care in the following four areas:

Child Health Quality Measure

The Center for Medicare and Medicaid Services (CMS) released a core set of child health measures in February 2011. In Illinois, HFS was collecting, analyzing and reporting on many of the core measures and in 2011 began developing the capacity to report on the remaining measures. In addition to the core measures, Illinois will work to identify, develop and test new measures in priority areas.

In conjunction with implementing the core measure set and developing new measures, Illinois will obtain provider input on data collection and reporting, report design, successes and barriers in using data for improvement activities, and priorities for new measures.

The overall goal for child health measures is for Illinois to report child quality measures (including the federal CMS core measures and additional state-developed measures) and for those measures to be used to drive quality improvement at the state level, within health plans and among providers.

Health Information Technology/Health Information Exchange (HIT/HIE).

Illinois will work to integrate plans for child health quality reporting, tracking, and quality improvement activities into the state's HIT infrastructure planning and building efforts to complement but not duplicate current HIE plans.

Coordinating with other HIT/HIE efforts such as the Governor's Office of Health Information Technology (OHIT) and the Electronic Health Record (EHR) Provider Incentive Program/ Meaningful Use, HFS will test technology solutions designed to improve care coordination within the medical home and assure that providers have access to health information that is timely and usable.

Goals HIE/HIT include making quality data more accessible to providers, feeding information back to pediatric and other health care providers and state agencies, and improving the availability of relevant and timely electronic information to improve quality and coordination of children's health care, reduce redundancy and cost, and improve clinical outcomes and patient satisfaction.

Improving and Enhancing Medical Homes

During the fall of 2011, HFS and the Illinois Chapter of American Academy of Pediatrics (ICAAP) began recruiting 200 practices to participate in the National Committee on Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) self-assessment survey tool to assess strengths and needs of practices serving as medical homes. ICAAP will use the practices' scores on the NCQA assessment to develop training specific to the identified needs. Following the self-assessment, practices are able to receive medical home resources, technical assistance, and training at their own pace over a two-year period at no cost.

In addition to the medical home assessment, 30-60 practices will be recruited to participate in quality improvement initiatives targeted to improving care coordination, child health measures and specific medical home domains.

The goals of the medical home initiative include strengthening the capacity of participating medical homes to provide high quality, family-centered care to Medicaid and CHIP-enrolled children, evaluating the impact of the self-assessment and interventions, and developing policy recommendations to improve HFS' medical home program.

Improving Birth Outcomes

HFS intends to improve birth outcomes through a variety of activities, including:

- Developing a prenatal electronic data set of information to be made available to delivery hospitals and all providers involved in a woman's care;
- Developing at least one health quality measure related to perinatal health;
- Recommending prenatal guidelines, referral protocols, and education;
- Engaging the Perinatal Network in quality improvement initiatives (such as educating providers about prenatal guidelines, referral protocols and education);
- Recommending protocols for care coordination; and
- Developing a public education campaign on the benefits of preconception, prenatal and interconceptional care.

During 2011, CHIPRA stakeholders identified the key information needed for the prenatal electronic data set and HFS is now exploring options for operationalizing the data set. CHIPRA stakeholders also started developing minimum prenatal guidelines that include required clinical elements, labs, education and referrals for non-complicated pregnancies. This work will continue into 2012, and will require HFS decisions on how to operationalize and implement the guidelines. A quality improvement initiative to educate providers about the guidelines is planned and will include the Perinatal Network.

XI. DENTAL PROGRAM

The HFS Dental Program is administered by DentaQuest of Illinois, LLC (DentaQuest). Under a competitively procured contract, DentaQuest is responsible for dental claims adjudication and payment, prior approval of services, ongoing reporting to the Department, quality assurance monitoring, and developing and maintaining the Dental Office Reference Manual. DentaQuest provides additional services including provider recruitment and training, enrollee education and referral coordination, interactive Web site, toll-free telephone systems, and other functions required to assure beneficiary access to needed dental services.

The Dental Program offers a comprehensive dental package of services to children, including preventive, diagnostic, and restorative services. Dental coverage is limited to diagnostic and restorative services for the adult population. Over 75 percent of the services/reimbursements provided through HFS' Dental Program are for children.

Beneficiary Outreach

HFS, in cooperation with DentaQuest, supports and encourages the concept of a "dental home" for all beneficiaries. Through the Beneficiary Outreach Initiative, beneficiary education and outreach programs were implemented in a variety of settings, including dental offices, medical offices, schools and community venues. A brochure is annually mailed to beneficiaries to reinforce the value of seeking treatment at a "dental home".

These efforts are succeeding, as evidenced by the 2011 HEDIS results. The Department's 2011 Annual Dental Visit HEDIS measurement shows that 54.55 percent of beneficiaries between 2 and 20 years of age, eligible for services, had at least one dental visit during the reporting period. This is up from 50 percent in 2009 and 51 percent in 2010.

Dental Program Expansion Efforts

HFS continues to work with publicly funded clinics to build the public health infrastructure necessary to improve dental care in underserved areas of the state. In July 2009, *P. A. 96-0039* provided \$2 million for dental clinic funding to the Capital Development Board over a three year period, as part of the 2010 capital budget. As of June 30, 2011, approximately \$1.8 million of the \$2 million in funds had been allocated to twenty-five entities to build or expand dental clinics. These grantees will be increasing access to dental services by adding seven new dental clinics and an additional 44 operatories throughout the state.

HFS has also developed a process to allow local health departments to claim Federal Financial Participation for the unreimbursed cost of providing dental services to Title XIX (Medicaid) clients. The cost must have been paid from local dollars and those dollars must not have been used to match any federal awards. To participate in the program the local health department must have a signed Interagency Agreement with HFS. Retroactive claiming from October 1, 2009 forward is allowed.

The All Kids School-based Dental Program offers out-of-office preventive dental services in a school setting to children ages 0-18 years. Providers who enroll with the All Kids School-based Dental Program must be able to render the full scope of preventive dental services including a comprehensive oral examination, prophylaxis, topical application of fluoride, and application of sealants. School-based providers must complete an Illinois Department of Public Health Proof of School Exam Form for each child seen, a School Exam Follow-up Form to be sent home with the student, and provide a referral plan for follow-up care. In addition, the provider must submit an

oral health score to HFS for each child examined. The score indicates the urgency level of follow-up care needed. Caregivers of those students whose scores indicate the most urgent need for care receive a letter from HFS reminding them of the importance of good oral health. The letter also includes contact information for DentaQuest.

HFS, in cooperation with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), continues to increase its efforts to improve oral health in young children (birth through thirty-six months of age). Under the Bright Smiles from Birth (BSFB) project, physicians, nurse practitioners, and FQHCs are trained by ICAAP to perform oral health screening, assessment, fluoride varnish application, anticipatory guidance and make referrals to dentists for necessary follow-up care and establishment of ongoing dental services. BSFB is currently operating in Cook County, the collar counties, Rockford and Peoria, with expansion efforts spreading downstate, as training resources permit.

A total of 2,219 providers have been trained, including residents under the supervision of a physician, and 397 primary care physicians (PCPs), representing an increase of 911 total providers and 218 PCP from 2009. The initiative has proven successful in improving access to dental care and studies confirm that fluoride varnish application is effective at reducing early childhood caries in young children. During calendar year 2010, over 8,000 unduplicated children under age three received a fluoride varnish application in a pediatric practice.

Reimbursement

DentaQuest reimburses dental providers according to the Department's fee schedule, with weekly payments received from the HFS based on DentaQuest's adjudicated claims for the respective week. Payments to dental providers are currently being made within 30 days of the receipt of a clean claim.

During fiscal year 2011, payments for dental care totaled over \$256 million. DentaQuest reported that 850,458 individuals under the age of 21 received over 6.4 million dental services, for a total expenditure of approximately \$194 million. For the same time period, 261,910 individuals ages 21 and over received 1.7 million dental services for a total expenditure of approximately \$62 million.

More information regarding the HFS Dental Program may be obtained at the following Department and DentaQuest websites: <<http://www.hfs.illinois.gov/mch/dental.html>> or <<http://www.dentaquestgov.com>>

XII. CARE MANAGEMENT

Managed Care

Illinois' Managed Care program currently consists of three delivery systems, the Integrated Care Program, the Primary Care Case Management (PCCM) program and the Voluntary Managed Care program. Each of these programs provides medical homes for their enrollees. Most Medical Assistance Program participants are required to be enrolled in one of these programs.

Integrated Care Program

In September of 2010, the Department awarded contracts to Aetna Better Health and IlliniCare to integrate and manage the care of the nearly 35,000 Seniors and Persons with Disabilities (SPDs) who live in suburban Cook, DuPage, Kane, Kankakee, Lake and Will Counties and are now enrolled in the Integrated Care Program (ICP). The ICP was the first mandatory managed care program for SPDs and was initially met with some resistance from both providers and enrollees. Over the next seven months the Department and the two plans worked extensively to recruit providers into the ICP networks. The final contracts were signed with Aetna Better Health and IlliniCare in April of 2011. Enrollment into the ICP began on May 1, 2011 and the enrollment roll-out was completed on January 1, 2012. The ICP the state's first integrated health care program was designed to improve the health care and quality of life for Illinois' SPDs in the Medicaid program. The integrated care delivery system brings together an individual's physicians, specialists, hospitals, nursing homes and other providers as part of an integrated care team. The care is organized around the patient's needs to keep him/her healthier and provide a more coordinated medical approach. Integrated care focuses on all of the factors that can affect a person's health and well-being and puts a plan in place to manage all of their health needs, whether those needs are physical, behavioral or social.

The five-year contracts with Aetna Better Health and IlliniCare will cost an estimated \$450 million annually in capitation payments to the two MCOs. The savings/cost avoidance estimates over the five-year contract are estimated to be \$200 million, as a result of: automated savings every year due to rates set for the companies at 3.9 percent below what is otherwise estimated to be spent on care for these enrollees; and lower growth rates (or estimated cost inflation) over time because of requirements for enhanced coordination of services and focus on prevention, especially as more services are added in Phase II and III.

Services

Under Phase I of the ICP, all standard Medicaid medical services, such as physician and specialist care, emergency care, laboratory and x-rays, behavioral health, pharmacy, dental, vision and substance abuse services are covered. Case management, an essential part of the ICP, is also a required service.

Phase II of the program, currently under development in consultation with stakeholders, advocates, and individuals in ICP, will go into effect in late summer of 2012. Services to be covered under Phase II will provide persons with disabilities the support they need to live more independently in the community. Those services include long term care services in nursing facilities or in the home through Home and Community-Based Services (HCBS) waivers. Phase II will reinforce Illinois' system of consumer-directed care for persons with disabilities.

Phase III, to be implemented in the future, will include long term care services for Intermediate Care Facilities for the Developmentally Disabled and Home and Community-Based Serviced waivers for persons with developmental disabilities.

Risk Stratification

Under ICP, participants are identified as needing care management or disease management through the use of predictive modeling, referrals, and through risk stratification. Enrollees are stratified once they join an integrated care health plan to determine the appropriate level of intervention. Enrollees are generally stratified into three levels: low, moderate and high risk. There is outreach and intervention at each level. Members identified as complex high risk receive the full range of care management services. Members with moderate risk are put into a standard care management program with service coordination and support as needed. Members who are identified as low risk receive prevention and wellness program services and education on condition-specific issues.

Integrated Care Team

Each health plan has a multidisciplinary integrated care team for enrollees identified as needing care management. The integrated care teams consist of clinical and non-clinical staff whose skills and professional experience complement and support each other in the oversight of enrollees' needs. Such teams consist of the enrollee, care coordinators, behavioral health care coordinators, community service liaisons, and the enrollee's providers. Care team functions include, but are not limited to: conducting enrollee assessments; developing an enrollee care plan in collaboration with the enrollee and their caregivers; communicating and coordinating care in a manner that ensure the enrollees physical and behavioral health needs are met.

Ultimately the decision of what type of health care the member receives is in the hands of the member – the ICP was designed to empower members to be in control of their own health care.

Performance Measures

The contracts with Aetna Better Health and IlliniCare Health Plan contain 30 performance measures that create an incentive for the two health plans to spend money on care that produces valued outcomes. They are rewarded for meeting pre-established targets for delivering quality healthcare services with measures such as, but not limited to, ensuring members follow up with a provider within 30 days after receiving a mental health diagnosis, following up with a provider within 14 days after an emergency room visit, and seeing a dentist annually.

Primary Care Case Management – Illinois Health Connect

The Primary Care Case Management Program (PCCM), Illinois Health Connect (IHC), was implemented in July 2006 and became fully operational in November of 2007. The program is based on the American Academy of Pediatrics' medical home initiative and seeks to provide a medical home for each client. As of June 30, 2011, there were over 2.0 million Medicaid enrollees that had either chosen or been assigned to a Primary Care Provider (PCP) for their medical home. Of these, just over 1.8 million enrollees were enrolled with a PCP in Illinois Health Connect for their medical home. Estimated savings from reduced inpatient hospitalizations and emergency room visits are over \$400 million since the program's inception. Through the Innovations Project, the Department is working to enhance the PCCM program to better coordinate care.

The program is mandatory for most persons covered by the Department's Medical Programs, including children and adults enrolled through the All Kids and FamilyCare programs and SPDs who are not enrolled in the ICP. Some populations, such as participants that have Medicare, are excluded from enrolling in Illinois Health Connect.

The goals of IHC are to improve the quality of health care and increase the utilization of primary and preventive care, reduce the usage of the emergency room for routine medical care, improve access to care through the availability of a provider network and expansion of providers and provide the most appropriate and cost-effective level of care.

Enrollees of IHC have a medical home through a PCP. Enrollees may choose their own doctor or clinic as their PCP if that doctor or clinic is enrolled with the Department as a provider and enrolled as a PCP with IHC. Establishing a medical home encourages the provision of healthcare services in the most appropriate setting and ensures access to preventive healthcare services. PCPs enrolled in IHC serve as an enrollee's medical home by providing, coordinating and managing the enrollee's primary and preventive services, including well child visits, immunizations, screening, and follow-up care as needed. The PCP also makes referrals to specialist for additional care or tests as needed. Having a single PCP ensures that enrollees have access to quality care from a provider that understands their unique health care needs. In counties in which the Voluntary Managed Care program is available, eligible enrollees may opt out of IHC to enroll with an MCO for their medical home.

Quality Initiatives

IHC's quality assurance program focuses on ongoing quality improvement and identifies and responds to opportunities for quality improvement in administrative practices and clinical functions of IHC. This quality improvement program includes strategies to assure access to care, evaluate provider and client education and to monitor and report on care coordination and utilization management. The Department and IHC worked with many provider and consumer groups to develop quality indicators and monitoring strategies to ensure providers receive the support they need to effectively manage the care of their enrollees and to ensure that the enrollees are receiving quality healthcare services. In order to assist PCPs in improving the quality of care for their enrollees, IHC makes the following quality tools available to all PCPs for use in their practice:

- *Panel Rosters* – Panel rosters help providers manage their patients' care by identifying patients are due for screening or checkups based on HFS claims data. These are available electronically or by paper copy.
- *Claims History Summaries* – Physicians treating Medicaid-eligible enrollees can access claims-based client health summaries that include medication and immunization histories, previous lab orders, hospitalizations and other medical procedures, electronically through the Department's secure MEDI system. With the claims history of a client, the provider can see a client's medical history, assist in assessing additional medical needs and determine adherence.
- *Provider Profiles* – Each IHC PCP receives a provider profile on a semi-annual basis (spring and fall) that summarizes the PCP's performance on specified clinical indicators. The profile is available electronically or via paper copy. The data reflected in the Provider Profiles is gathered from HFS claims data.
- *Specialty Resource Database*: IHC assists PCPs in connecting enrollees to specialty care through the Specialty Resource Database. This provides specific information on the circumstances under which specialists are available to provide care to an eligible client. A specialist's registration in the database will allow Illinois Health Connect to direct enrollees and PCPs to the most appropriate specialist provider.

Illinois Health Connect Medical Home Requirement

To continue the ongoing efforts to “connect” the patients with their medical home to increase the use of the medical home and support continuity of care, IHC utilizes a medical home edit program called “Illinois Health Connect Referral System.” The referral program requires enrollees to see their own PCP, or a provider or clinic affiliated with their PCP, for most primary and preventive care. IHC PCPs seeing IHC patients who are not enrolled on their panel, or on an affiliated PCP’s panel, on the date of service must obtain a referral from the patient’s PCP in order to be reimbursed by the Department. PCPs are able to submit referrals for their patients to see other enrolled PCPs. Physicians that are not enrolled in IHC as a PCP do not require a referral in order to see an IHC patient. Additional information about Illinois Health Connect can be found at: www.illinoishealthconnect.com

Voluntary Managed Care

Voluntary Managed Care program has been a healthcare option for medical assistance participants in Illinois since 1976, and continues to be a choice even with the implementation of the PCCM program. Overall, MCO enrollment increased 6.4 percent during fiscal year 2011, from 196,454 participants at the beginning of the fiscal year to 209,069 at the end of the fiscal year.

The Voluntary Managed Care program is available to participants residing in the counties of Adams, Brown, Cook, Henry, Jackson, Kane, Lee, Madison, McHenry, Mercer, Perry, Pike, Randolph, Rock Island, St. Clair, Scott, Washington and Williamson. Medical Assistance program participants residing in these counties may opt out of the PCCM program (IHC) and choose a Managed Care Organization (MCO) as their medical home. MCOs include Health Maintenance Organizations (HMOs) and Managed Care Community Networks (MCCNs). HMOs are licensed by the Department of Insurance and contract with the Department on an at-risk basis to provide medical services to their enrollees. MCCNs are provider-sponsored organizations within Illinois, established solely to serve Medicaid clients that have been certified by the Department as meeting requirements established by the Department for such organizations.

Currently, HFS contracts with Harmony Health Plan, a HMO, Meridian Health Plan, a HMO, and Family Health Network, a MCCN, to manage the provision of healthcare for enrollees. With the exception of financial solvency and licensing requirements, the Department’s contractual requirements with these entities are the same. These MCOs offer the same comprehensive set of services to their enrollees, as are available to the fee-for-service population, excluding pharmacy, dental and all services provided by an optometrist. Although these services are not covered under the MCO contract, MCO enrollees may receive these services through any provider enrolled with the Department without a referral from the MCO.

The MCOs participating in the Voluntary Managed Care program are contractually required to provide case and disease management services to members with specific diagnosis or who require high cost and/or extensive services. The MCO contract specifies the parameters of the MCOs case and disease management program and systems. The MCOs are required to submit its case management and disease management policy/plan and report monthly on these programs, which are reviewed and monitored by the Department and the contracted external quality review organization (EQRO). Additionally, the EQRO provides technical assistance to the Department and the MCOs as well as oversight and monitoring of the quality assurance components of the MCO contract. In 2010, the EQRO performed a

comprehensive onsite review of each plan's case and disease management systems. The results of these reviews can be found in the [2009-2010 External Quality Review Technical Report](#)

Screening, Assessment and Support Services Program

Since the implementation of the *Children's Mental Health Act of 2003 (Public Act 93-0495)*, HFS has worked in collaboration with the Illinois Departments of Children and Family Services (DCFS) and Human Services (DHS) to administer the Screening, Assessment and Support Services (SASS) program. SASS is a statewide crisis system designed to ensure a consistent service response to children and youth experiencing a mental health crisis whose care requires public funding from one of the agencies listed above. The SASS system features a single point of entry know as the CARES (Crisis and Referral Entry Service) and a coordinated provider network aimed at proving short-term crisis intervention and stabilization, level of care transitional services; discharge planning and care coordination services for SASS eligible individuals. In fiscal year 2011, the SASS program served in excess of 24,000 unique children and youth while the three departments expended nearly \$30 million in funding to community mental health providers in support of this program.

Psychiatric Consultation Phone Line — Illinois DocAssist

Healthcare and Family Services (HFS) in collaboration with the Illinois Departments of Human Services, Division of Mental Health (DHS-DMH) and the Illinois Children's Mental Health Partnership continues to support and administer the Illinois DocAssist program. Illinois DocAssist is a statewide psychiatry consultation and training service for primary care providers in Illinois serving Medicaid enrolled children and youth under age 21. DocAssist is staffed by child and adolescent psychiatrists, as well as allied medical professionals from the University of Illinois at Chicago, Department of Psychiatry. The consultation service seeks to meet the need for early and effective behavioral health (mental health or substance use) intervention for children and youth. The consultation service is provided directly by a child and adolescent psychiatrist to an inquiring Primary Care Provider or serving practitioner using the DocAssist toll-free telephone line: 1-866-986-ASST (2778). In addition to providing direct phone consultation, DocAssist supports the HFS provider base seeking to treat children and youth by offering continuing medical education programs and educational seminars on common youth and adolescent behavioral health issues. In addition to maintaining their toll-free line, Illinois DocAssist makes resources available to the general public and Medicaid-funded providers via the UIC supported web site: <http://www.psych.uic.edu/docassist/>

XIII. MEDICAID PROVIDER ASSESSMENT PROGRAMS

The Provider Assessment Program was implemented in July 1991. It was the result of a joint effort by the General Assembly, the affected health care industries, and the Department to secure funding necessary for the Medical Assistance Program. The program makes use of a provision in federal law that allows States to claim federal financial participation (FFP) on payments for services that are funded from the receipts of eligible health care provider taxes.

Provider assessments by provider class and year of assessment, fiscal years 1992-2011, in millions of dollars				
Fiscal year	Provider assessments			
	Total	Hospitals	Nursing facilities	ICFs/MR
Total	\$8,666.70	\$6,936.10	\$1,347.50	\$ 383.10
1992	398.2	254.2	120.0	24.0
1993	478.9	254.5	195.6	28.8
1994	335.7	266.4	55.0	14.3
1995	357.3	286.2	55.6	15.5
1996	271.8	199.0	56.9	15.9
1997	232.1	158.4	57.7	16.0
1998	74.5	--	58.2	16.3
1999	76.0	--	59.0	17.0
2000	76.9	--	59.5	17.4
2001	77.4	--	59.3	18.1
2002	77.8	--	58.9	18.9
2003	78.5	--	58.7	19.8
2004	78.5		58.4	20.1
2005	713.8	635.4	57.6	20.8
2006	77.4	-	56.6	20.8
2007	810.9	733.4	56.7	20.8
2008	1,542.9	1,466.8	56.0	20.1
2009	976.1	900.0	56.0	20.1
2010	966.0	890.9	55.9	19.2
2011	966.0	890.9	55.9	19.2

The availability of funds generated by the assessment programs has helped the Department provide critical institutional services to some of the neediest and most frail Illinois residents. Since inception, this program has generated over \$17 billion in additional funding for the Medical Assistance Program (\$8.7 billion in provider taxes and \$8.4 billion in FFP).

During fiscal year 2011, nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) continued to be taxed pursuant to the provisions of Public Act 89-0021. Since 2007, the \$1.50 per licensed day bed tax on NFs has generated nearly \$56 million in tax revenue annually, which resulted in

approximately \$52 million in FFP. The 5.5 percent tax on the adjusted gross revenues of ICFs/MR generated nearly \$19.2 million in tax revenues. A hospital provider tax that ended on March 31, 1997, was reinstated in fiscal year 2004 and subsequently revised in fiscal years 2006 and 2009 and continues through fiscal year 2014. During fiscal year 2011, the hospital provider tax totaled approximately \$891 million.

XIV. PROVIDER REIMBURSEMENT

To receive payment for medical care, services or supplies, a provider must enroll and be approved for participation by the Department. Enrollment information can be found on the Department's Web site at :<<http://www.hfs.illinois.gov/enrollment/>>.

At the end of fiscal year 2011, a total of 67,768 providers were enrolled with HFS, representing an increase of 5,685 providers over fiscal year 2010 year-end. Refer to Table IV for a breakout by type of provider/service. This increase is partially attributed to the Department's statewide PCCM program, Illinois Health Connect.

The Department reimburses enrolled providers for covered medical care and services provided to participants who are eligible on the date the service is rendered. The range of services for which the Department will pay varies depending on the program or plan under which the participant is covered. Refer to Appendix A for information on the eligibility groups and program descriptions. The objective of the Department's Medical Programs is to enable eligible participants to obtain medically necessary care.

Medically necessary care is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment. Preventive care is covered in certain circumstances. Prior approval requirements may be imposed for some services such as, but not limited to, certain prescription drugs, durable medical equipment, prosthetics and disposable medical supplies.

Providers must bill the Department their usual and customary fee charged to the general public. The Department's payment is the lesser of the provider's charge or the maximum fee established by the Department for the service or item. The Department's fee schedules may be found on the Web site at: <<http://www.hfs.illinois.gov/reimbursement/>>.

More detailed reimbursement information on several provider types is described in the following sections.

XV. REIMBURSING HOSPITALS

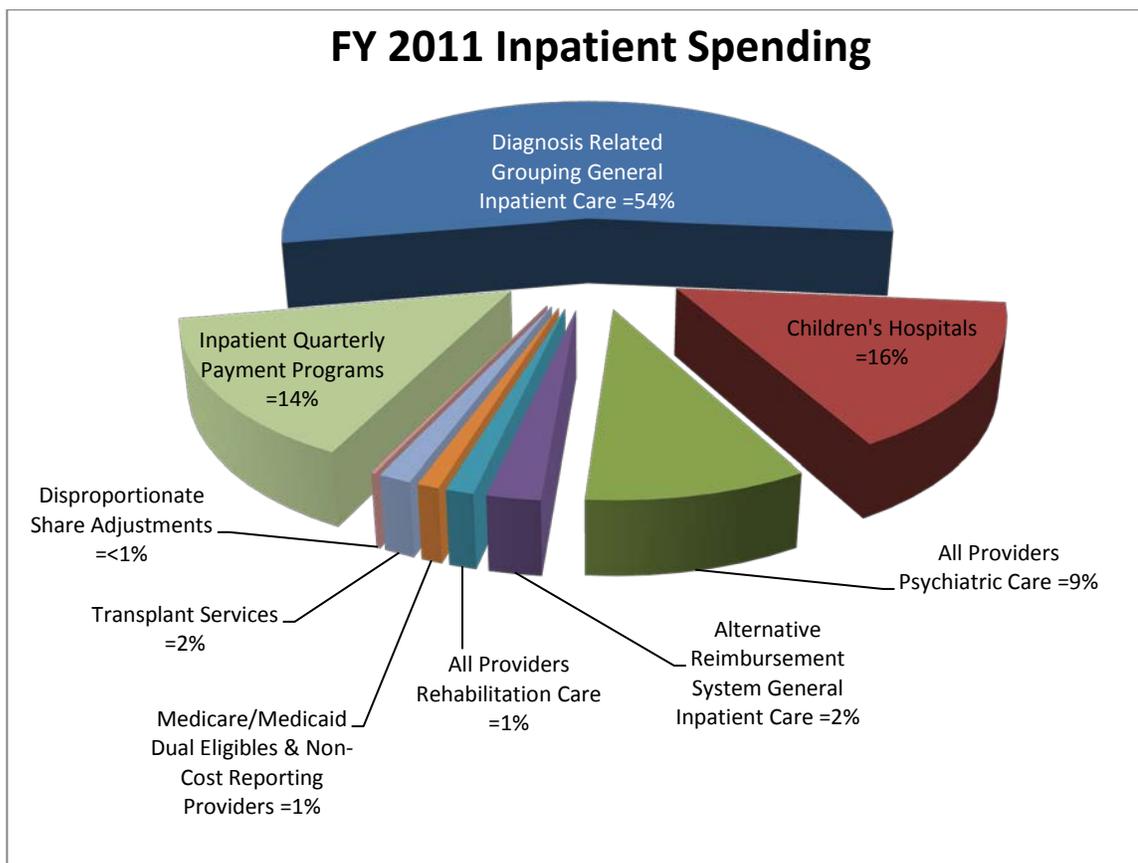
Inpatient Hospital Services - General Revenue Fund (GRF)

Although the Department began significant efforts in the direction of redesigning the Inpatient Hospital Reimbursement system no material changes occurred in 2011. The base hospital reimbursement has been essentially frozen for well over a decade. It is also important to note that the base hospital reimbursement system accounts for roughly half of inpatient payments. The other half is in the form of static payments that are on top of the base rate and are not necessarily related to the actual services provided in the current fiscal year.

As shown in the graph on the following page, slightly more than half of hospital inpatient payments are made pursuant to a DRG based system that was implemented in the early 1990's. Some hospitals are specifically excluded from the DRG-PPS system and are reimbursed under the per-diem Alternative Reimbursement System. These include psychiatric hospitals, rehabilitation hospitals, children's hospitals, long term stay hospitals, hospitals organized under the University of Illinois Hospital Act, or county owned hospitals in a county with a population more than three million and non-cost reporting out of state hospitals. In addition, all hospitals operating distinct psychiatric or rehabilitation units are also reimbursed under the Alternative Reimbursement System per-diem method for these services.

Date of service spending levels for base reimbursements in fiscal year 2011 increased one percent to \$2.12 billion from the 2010 amount of \$2.1 billion. The average length of stay for all providers and claims remained the same and there was approximately a two percent increase in the average payment per day for the same time period. This increase can be attributed to the growing value of hospital outlier payments. Outlier payments are made on hospital inpatient admissions that deviate significantly from established norms, i.e., excessively long lengths of stay or expensive admissions. It should be noted that effective November 1, 2011; the outlier threshold factor was increased, thus lowering the amount of outlier liability. At the time of this report, not all of the retroactive adjustments had been applied to recoup the overpayments and therefore, the final increase in payment per day will be slightly lower than 2 percent. While the base payments increased by about 1 percent, there was an 8 percent corresponding change in static payments. Consequently, the overall increase in reimbursement for hospitals was 2 percent, up to \$2.5 billion from \$2.44 billion in fiscal year 2010. A graphic depiction of inpatient spending for fiscal year 2011 can be found on the following page.

FY 2011 Inpatient Spending



Disproportionate Share Hospitals

As required by federal law, hospitals serving a disproportionate number of low-income patients with special needs are to be given an appropriate increase in their inpatient rate or payment amount. In addition, states are federally mandated to provide the increased payment to any hospital whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate, or whose low-income utilization rate exceeds 25 percent.

In fiscal year 2011, 72 hospitals qualified for the DSH adjustment with a total spending of \$5 million. In addition, six state-operated psychiatric hospitals qualified for DSH because their low-income utilization rate exceeded 25 percent. DSH spending to the state operated psychiatric facilities was \$89.4 million in federal fiscal year 2011 and the University of Illinois was paid \$26.6 million. The average DSH payment for hospitals other than state operated psychiatric facilities and the University of Illinois was \$7.45 per DSH day in fiscal year 2011, a decrease from the \$10.32 per DSH day paid in fiscal year 2010.

In accordance with Federal guidelines set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1993 in the Social Security Act 1923 g), the Department performs an annual OBRA calculation to ensure that spending to each hospital does not exceed the combined costs of services to the Medicaid and uninsured populations. Twenty-four hospitals qualified for DSH payments in 2011, but did not receive the payments because the federal OBRA cap would have been exceeded. These hospitals have been included in the count of total DSH eligible hospitals, although their calculated rates have not been factored into the average DSH rate.

Medicaid Percentage Adjustment

Hospitals qualify for the Medicaid Percentage Adjustment (MPA) if they are a children's hospital, hospitals providing a high percentage of Medicaid and obstetrical care, have a Medicaid inpatient utilization rate-qualifying threshold to one-half standard deviation above the mean or their low income utilization rate exceeds 25 percent.

Hospitals receiving MPA payments receive an additional per diem payment known as the Medicaid High Volume Adjustment (MHVA) Payment, with the exception of hospitals operated by the University of Illinois, the Cook County Health and Hospitals System and the State-operated psychiatric hospitals. The MHVA Payment is added to the hospital's inpatient DRG or per diem payments.

Under these qualifying criteria, 87 hospitals qualified for MPA payments with rates ranging from \$45.30 to \$313.51. Twenty children's hospitals received MHVA payments of \$217.43 per day, and 67 other hospitals received MHVA payments of \$108.72 per day.

Outpatient Hospital Services – GRF

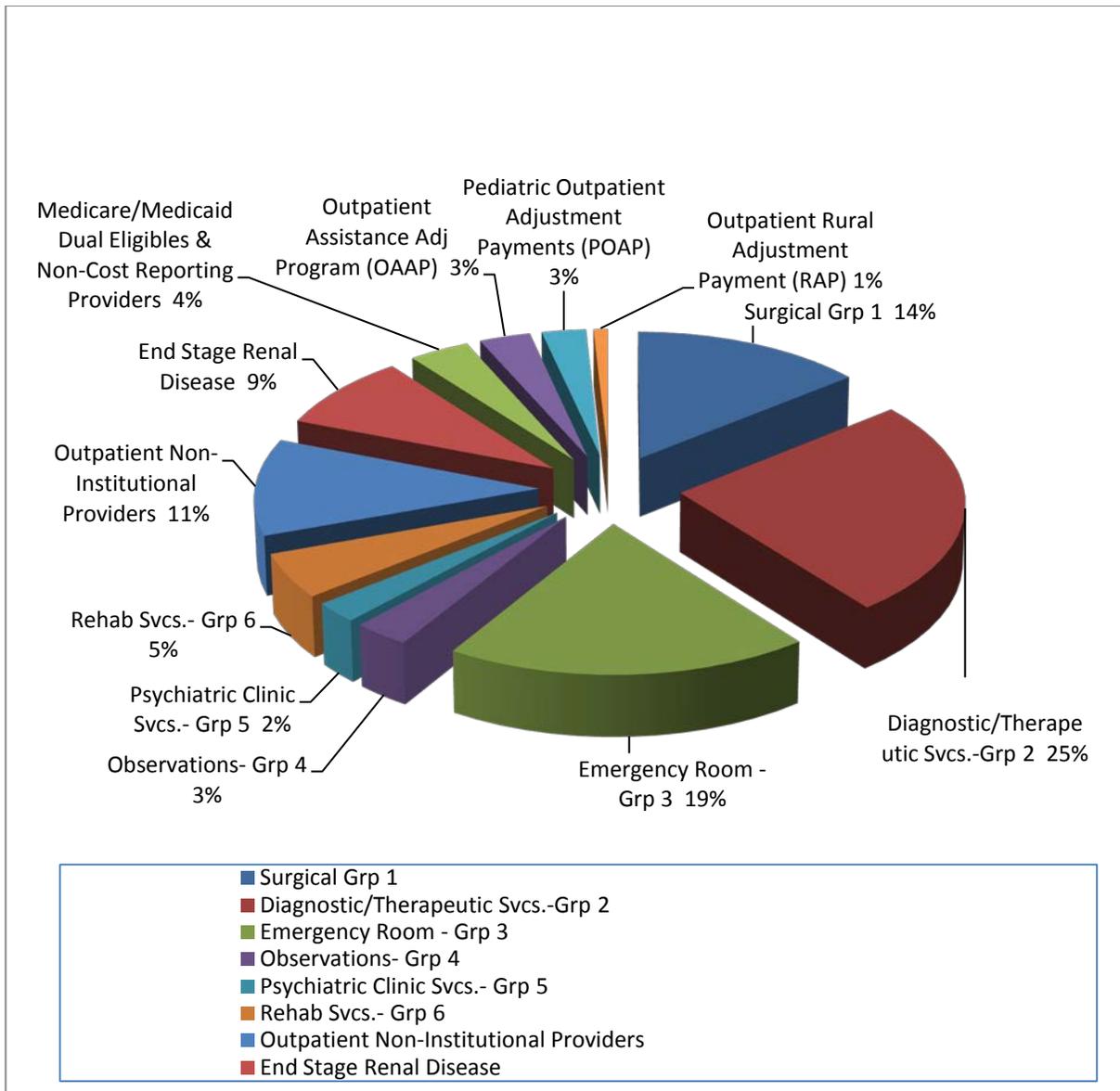
Ambulatory Care Services

No major structural changes were enacted during fiscal year 2011. Outpatient spending for fiscal year 2011 increased approximately 7.6 percent, primarily related to growth in eligibility.

Total date of service outpatient spending for fiscal year 2011 was \$739 million. The majority of general hospital outpatient claims fall into one of the following six Ambulatory Process Listings: Group 1-Surgical; Group 2-Diagnostic and Therapeutic; Group 3-Emergency Department Services; Group 4-Observation Services; Group 5-Psychiatric Services and; Group 6-Rehabilitation Services.

The chart on the following page depicts total Outpatient spending in fiscal year 2011, including the Ambulatory Procedure Listing Payments, Outpatient Static, Payments, Renal, and Non-institutional Providers. These payments are shown as a percentage of the total.

FY 2011 Total Outpatient Payments by Category



Inpatient Static Payments

Critical Hospital Adjustment Payment

Since its inception in fiscal year 1996, the Critical Hospital Adjustment Payment (CHAP) program has provided hospitals that serve a high number of Medicaid enrollees with additional funding to ensure that the state's most needy individuals continue to have access to quality healthcare services.

In fiscal year 2011, approximately \$228 million was paid to eligible hospitals through the CHAP program. Hospitals may qualify to receive payments under any of the following four CHAP program components:

- **Trauma Center Adjustment:** This payment is made to qualifying Level I and Level II Trauma Centers throughout Illinois and neighboring states. The Level I and Level II Trauma designations are determined by the Department of Public Health. In fiscal year 2011, this program distributed approximately \$41 million to 36 trauma centers.

- **Rehabilitation Hospital Adjustment:** Hospitals that qualify as rehabilitation hospitals and are accredited by the Commission on Accreditation of Rehabilitation Facilities may be eligible to receive funding through this adjustment. In fiscal year 2011, four qualifying rehabilitation hospitals received a little over \$11 million in funding.
- **Direct Hospital Adjustment:** The Direct Hospital Adjustment is the largest component of the CHAP program. The Direct Hospital Adjustment provides additional funding to hospitals serving a high volume of Medicaid patients. Payment rates are based on a sliding scale that increases with the hospital's Medicaid and obstetrical care utilization. In fiscal year 2011, 30 qualifying hospitals received approximately \$159 million in payments under this program.
- **Rural CHAP:** This program provides additional funds to hospitals in rural areas of the state to ensure that Medicaid patients throughout Illinois have access to quality medical care. During fiscal year 2010, 88 qualifying hospitals received close to \$16 million in payments through this program.

Pediatric Inpatient Adjustment Program

The Pediatric Inpatient Adjustment Program (PIAP), implemented in fiscal year 1998, and expanded in fiscal year 2000 to include all children's hospitals, provides enhanced inpatient Medicaid payments to children's hospitals for psychiatric or physical rehabilitation care provided to children less than 18 years of age during the adjustment base year. In fiscal year 2011, 15 children's hospitals received approximately \$11 million under the PIAP.

Psychiatric Adjustment Payments

The Psychiatric Adjustment Payments program was created to ensure access to specialized psychiatric care in regions of the state where access to care has diminished. In fiscal year 2011, the program paid approximately \$4 million to six acute care facilities with specialized psychiatric care units.

Rural Adjustment Program

During fiscal year 2011, the Department continued the Rural Adjustment Program to provide additional funds to help close the cost coverage gap for hospital providers in rural areas, who have been deemed by the Department of Public Health, as critical to the provision of healthcare in Illinois. The program is divided into two distinct components to recognize volume and cost coverage in both the inpatient and outpatient settings. Total funding for the program has been capped at \$7.0 million since fiscal year 2003. In fiscal year 2011, a total of 48 providers qualified for the inpatient portion of the program with payments totaling approximately \$584,000.

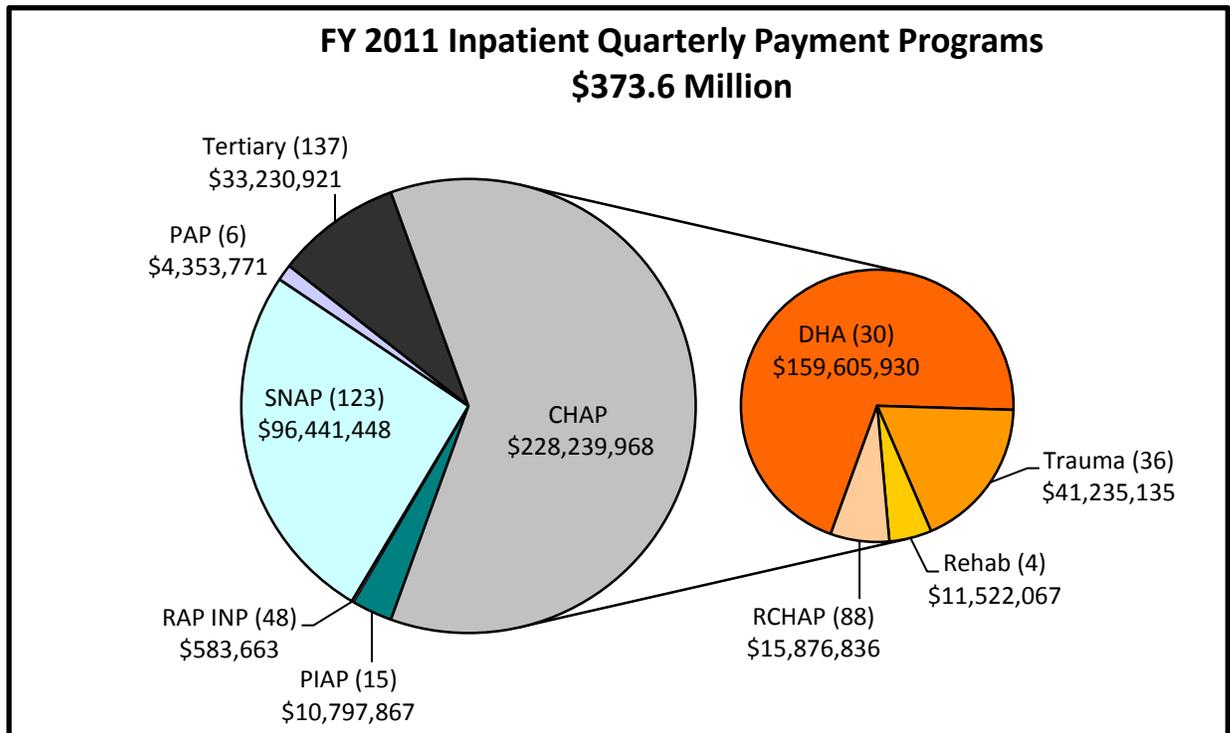
Safety Net Hospital Adjustment

The Safety Net Adjustment Payment (SNAP) is a quarterly payment program begun in fiscal year 2002. Through the SNAP program, the Department is able to direct additional funding to Illinois hospitals that serve high volumes of Medicaid patients and to rural hospitals providing critical Medicaid services in their community. By providing necessary resources to the state's most critical hospitals, the Department ensures its enrollees receive essential healthcare. Hospitals located outside of Illinois, county-owned hospitals, hospitals organized under the University of Illinois Hospital Act, psychiatric hospitals and long-term stay hospitals are not eligible for SNAP. In fiscal year 2011, a total of 123 providers qualified for the program with payments totaling a little over \$96 million.

Tertiary Care Adjustment Payments

The Tertiary Care Adjustment payments were designed to assist hospital providers in the delivery of greater access to essential, higher level complex healthcare services. A total of 137 providers qualified for Tertiary Care Adjustment payments during fiscal year 2011, with payments totaling approximately \$33 million.

Total GRF inpatient static payments made for each program, as well as the number of facilities qualifying under each program, may be seen in the chart below. Please note, several hospitals qualified under more than one program.



Outpatient Static Payments

Outpatient Assistance Adjustment Payments

Implemented in January of 2007, the Outpatient Assistance Adjustment Payment program (OAAP) provides additional funding to high volume Medicaid providers, to ensure access to quality healthcare for the Department's medical assistance enrollees requiring care on an outpatient basis. Qualifying hospitals must meet minimum thresholds for Emergency Care percentages, as well as provide a large number of outpatient services. During fiscal year 2011, OAAP payments totaled slightly over \$23 million.

Pediatric Outpatient Adjustment Program

Pediatric Outpatient Adjustment Program (POAP) was developed and implemented in fiscal year 1998 to ensure access for specialized outpatient services at children's hospitals. In order to qualify for this program, a facility must be licensed as a children's hospital and possess a pediatric outpatient percentage greater than 80 percent during the pediatric outpatient adjustment base period. In fiscal year 2011, the program paid almost \$20 million to seven separate children's hospitals.

Other Static Payments

County Trauma Center Adjustment Program

Under the County Trauma Center Adjustment Program, all Level I and Level II Illinois trauma centers are entitled to receive additional Medicaid add-on payments. The program is funded by a portion of the monies collected through traffic fines and citations issued by Illinois counties and then submitted to the Office of the State Treasurer on a quarterly basis. Upon receipt of these funds, the State Treasurer divides the amount equally between the Department and the Department of Public Health. The Department utilizes its portion of the funding to make the County Trauma Center Adjustment payments. The Department receives federal matching funds on its spending, thus doubling the amount available to be paid to the facilities each quarter. In fiscal year 2011, almost \$13 million was paid out to Illinois' 64 qualifying Level I and Level II trauma centers.

Excellence in Academic Medicine

The Excellence in Academic Medicine Act (30 ILCS 775/1 et seq.) enacted on July 3, 1996, provides funding to large teaching hospitals, in conjunction with their respective medical schools that qualify as academic medical centers. The research, technology, and programmatic development projects funded in fiscal year 2011 have helped Illinois reach the goals of the Excellence in Academic Medicine Act.

The general purpose of the Act is to stimulate excellence in academic medicine in Illinois, to elevate Illinois as a national center for healthcare innovation, and to reverse the current healthcare trade imbalance so that Illinois citizens may obtain the highest quality post-tertiary care at home. Funding is being used to support preliminary studies for research, which may eventually be funded by the National Institutes of Health. These academic hospitals report that an overwhelming majority of the research programs funded by this Act have a high likelihood of success in applying research findings to the clinical setting, and should have a substantial impact on the practice of mainstream medicine. A number of supported projects included prevention of recurrence of depression, early cancer detection, organ, bone marrow or stem cell transplantation, gene therapy, and comprehensive patient safety programs. Total statewide awards are based on the level of funding appropriated by the General Assembly, which has increased from \$6.8 million in fiscal year 1997 to \$27.6 million in fiscal year 2011, in which ten academic medical centers were deemed qualified. State expenditures for this program are eligible for federal financial participation.

Illinois Hospital Access Improvement Payments

In accordance with *P. A. 95-0859*, the Department is required to make hospital access improvement payments for fiscal year 2009 through fiscal year 2013, which will allow improved access to quality health care and increase both the adequacy and the equitable distribution of Medicaid hospital payments. Total annual payments are \$1.5 billion, which will garner over \$750 million annually in federal funding. The increased funding will enable hospitals to preserve and improve access to the essential health care services their patients and communities depend on. Most hospitals will receive a significant increase in Medicaid payments, reducing the disparity among hospitals' payment-to-cost ratios. The annual payments for fiscal years 2009 through 2013 are: Medicaid High Volume Adjustment Payments; Inpatient Services Adjustment Payments; Capital Needs Payments; Obstetrical Care Payments; Trauma Care Payments; Supplemental Tertiary Care Payments; Crossover Care Payments; Magnet Hospital Payments and; Ambulatory Procedure Listing Increase Payments.

XVI. REIMBURSING LONG TERM CARE FACILITIES

Reimbursement rates for long term care facilities are calculated based on three separate components: nursing, capital, and support, which together comprise the facility's per diem rate. Capital and support are based on cost reports the facilities submitted to the Department each year. The nursing component is based on cost reports and federally mandated assessments, minimum data sets (MDS), MDS-based clinical information. MDS-based clinical information is used to update for case-mix changes in the nursing component and newer cost reports are used in calculating the support component of the reimbursement rate.

In January 1994, a freeze was put in place on the methodology for determining rates of long term care facilities. Even though the rate methodology has been frozen, specific legislative action and corresponding appropriations have resulted in average facility nursing rates increasing from \$69.78 in January of 1994 to \$119.55 on June 30, 2011. Additionally, *P.A. 096-1530* sunsets the current reimbursement structure for nursing facilities and directs the Department to redesign the rate methodology by July 1, 2012.

Long standing exceptions to the rate freeze still allowed for setting a facility's per diem rate based on specific changes in the facility's costs and the resident case-mix (89 Ill. Adm. Code 153.100). In fiscal year 2011, these included the following:

- *New facilities* – Facilities that are new to the Medicaid program do not have an established rate. For the nursing and support components of the rate, these facilities are given the median rate for their geographic area. The facility's capital costs are used to determine the capital portion of the rate.
- *Capital Exceptions* – Facilities that have increased building costs by more than 10 percent, in the form of improvements or additional capacity, may request an adjustment to the capital component of their facility's rate. Capital exceptions resulted in rate changes for 96 facilities in fiscal year 2011.
- *Initial Cost Reports* – Under certain circumstances, recently enrolled facilities are required to file an initial cost report that may result in capital and/or support component revisions. Initial cost reports revised rates for one home in fiscal year 2011.

XVII. REIMBURSING MANAGED CARE ORGANIZATIONS

Managed Care Organizations (MCOs)

MCOs participating in the Department's Voluntary Managed Care Program and Integrated Care Program are reimbursed on a capitation basis. The Department's actuary develops the MCO rates based on fee-for-service claims experience and enrollment data for a comparable fee-for-service population. There are adjustments for healthcare management, trend and health plan administration. The capitation rate (per member per month) is paid based on age/gender rate cells.

Voluntary Managed Care Program

In the Voluntary Managed Care Program, the capitation is for the provision of all covered services required to be provided through the MCO, including physician, inpatient and outpatient hospital, clinic services and many additional services. Excluded from the capitation are payments for hospital deliveries. The Department reimburses MCOs separately for each hospital delivery paid by the MCO. The payments for deliveries are generated by the Department based on the MCO's hospital encounter data that groups into specific diagnostic related groupings (DRGs). Other services excluded from the capitation, and reimbursed by the Department's fee-for-service system, include pharmacy services provided through a pharmacy, dental services, optical services, including services provided by an optometrist, nursing facilities services after the first 90 days, and several minor specialized services.

Integrated Care Program

Under the Integrated Care Program, the MCOs are reimbursed on a capitation basis for the entire spectrum of Medicaid covered services, including physician and specialist care, hospitalization, pharmacy, laboratory, dental, behavioral health, substance abuse and many other services. The capitation rate is paid based on 6 different population rate cells, which are broken out based on the type of enrollee (community residents, nursing facility residents, enrollees in waivers, etc.).

HFS ensures that quality safeguards are in place by contractually requiring:

- pay-for-performance measures to incentivize spending on care that produces healthy quality-of-life outcomes;
- payment withholds when the MCOs do not spend their capitation payments on care that produces quality outcomes, and;
- a medical loss ratio (MLR) of 88 percent, meaning that 88 percent of the revenue from the contract must be spent on healthcare services to enrollees.

ICP Incentive Pool Payments

In addition to the monthly capitation payments, the integrated care plans can earn incentive pool payments based on their performance of 15 quality metrics. The incentive pool is funded through a withhold of a portion of the capitation rate, 1 percent in the first measurement year, 1.5 percent in the second measurement year, and 2 percent the third measurement year. The withheld amount is combined with an additional bonus amount funded by the Department to equal 5 percent of the capitation rate. Calendar year 2012 will be the first measurement year using calendar year 2010 baseline measurements. The integrated care plans are not eligible to earn incentive pool payments if they do not meet a minimum performance standard.

Primary Care Case Management – Illinois Health Connect

Monthly Care Management Fee

Primary Care Physicians (PCPs) participating in Illinois Health Connect (IHC) receive a monthly care management fee for each participant they accept as a patient. The following monthly care management fee is paid to PCPs enrolled in IHC on a capitated basis for each person whose care they are responsible to manage: \$2.00 per child (under 21 years of age), \$3.00 per adult and \$4.00 per adult with disability or elderly adult enrollee. The care management fee is paid, even if the enrollee does not receive a service that month and is in addition to the fee-for-service or encounter payments the PCP receives for medical service rendered. Reimbursement to the IHC program administrator is a result of the contractor's winning bid, and is based on a per member/per month amount and performance of various contractual requirements.

IHC Bonus Payment for High Performance Program

In addition to the monthly care management fee, the Department established an annual Bonus Payment for High Performance Program. Under this program, qualifying IHC PCPs are eligible to receive annual bonus payments for each qualifying service under a bonus measurement. The bonus program is intended to increase the quality and access to care for enrollees by encouraging PCPs to provide primary and preventive services in accordance with the quality measurements and to drive the adoption of quality improvement initiatives within their practices.

The bonus payments are based on services provided for all enrollees on the PCP's panel on December 1st of the program year who have received one or more of the following services:

- Immunization Combo3
- Developmental Screening
- Asthma Management,
- Diabetes Management
- Breast Cancer Screening

The HEDIS 50th percentile is the benchmark for these measurements, with the exception of the Developmental Screening, which is established by the Department.

Under the initial year of the bonus program (calendar year 2008), a total of 4,126 PCPs, at 4,433 sites, qualified for a bonus payment for meeting or exceeding one or more of the qualifying measurements.

The bonus payments for 2009 were \$25 per qualifying enrollee, per qualifying event. In total, there were 132,496 qualifying events, resulting in a little over \$3 million in bonus payments to qualifying PCPs.

The bonus payments for 2010 continued to be \$25 per qualifying enrollee, per qualifying event. In total, there were 147,723 qualifying events, resulting in nearly \$4 million in bonus payments to qualifying PCPs.

The bonus payment program has stimulated quality improvement initiatives within many PCP practices, which has resulted in increased access to care and improved quality of care for enrolled enrollees. The 2009 and 2010 bonus program measurements and qualifying events by measurement and bonus value are provided in the table on the next page.

2009 and 2010 IHC Bonus Program Measurements

2009 IHC Bonus Program			2010 IHC Bonus Program		
Measurement	Qualifying Recipients	Bonus Value	Measurement	Qualifying Recipients	Bonus Value
Asthma Mgmt	19,118	\$477,950	Asthma Mgmt	23,504	\$587,600
Breast Cancer	13,055	\$326,375	Breast Cancer	18,184	\$454,600
Developmental Screening	66,115	\$1,652,875	Developmental Screening	73,672	\$1,841,800
Diabetes Mgmt	14,077	\$351,925	Diabetes Mgmt	17,254	\$431,350
Immunizations	20,131	\$503,275	Immunizations	15,109	\$377,725
Totals	132,496	\$3,312,400	Totals	147,723	3,693,075

Managed Care Quality Assurance

See Section XXI. Quality Assurance, Utilization and Control for quality assurance for managed care programs.

XVIII. REIMBURSING PHARMACY SERVICES

Coverage of prescription drugs is limited to products made by companies that have signed rebate agreements with the federal Centers for Medicare and Medicaid Services (CMS). This encompasses the vast majority of pharmaceutical manufacturers. The Department restricts coverage of some reimbursable drugs via a prior authorization process and regularly evaluates which drugs should be subject to prior approval based upon the relative safety, efficacy, effectiveness and costs for covered medications. The Department has an agreement with the Illinois State Medical Society and their Committee on Drugs and Therapeutics to provide clinical reviews and advisory recommendations on which drugs should require prior authorization. This panel meets quarterly for the purpose of conducting drug reviews.

In fiscal year 2011, the Department continued its commitment to develop and maintain cost-effective State Maximum Allowable Charge (MAC) reimbursement methodologies that provide economically fair and consistent rates for its participating pharmacies. In November 2009, the Department announced a new partnership with Goold Health Systems to develop and maintain a comprehensive listing of State MAC reimbursement rates. Goold Health Systems is an established leader in pharmacy services benefit administration and provides the Department with invaluable experience and knowledge of pharmaceutical market dynamics. This specialized pharmaceutical market expertise ensures that the Department maintains drug rates that are equitable to retail pharmacies, while at the same time represent sound cost containment principles. The Department provides public notice of proposed revisions and additions to monthly State MAC rates at least 30 days prior to effective dates. This policy ensures that pharmacy providers may review and, if necessary, appeal the adequacy of State MAC rates before final rates are implemented. Proposed and final State MAC rates can be accessed through a web link on the Department's Web site: www.ilsmac.com

Reimbursement Rates

During fiscal year 2011, pharmacy reimbursement rates remained constant at fiscal year 2010 levels. The reimbursement rate for single-source medications (i.e., brand name) is average wholesale price (AWP) minus 12 percent plus a dispensing fee of \$3.40. Multi-source medications (i.e., generics) are reimbursed at AWP minus 25 percent plus a dispensing fee of \$4.60. The Department's maximum price for each drug continues to be the lesser of AWP minus the applicable percentage, the Federal Upper Limit for that drug, the State's MAC or a pharmacy's usual and customary charge.

Drug Rebate Program

The drug rebate program was mandated under the federal Omnibus Budget Reconciliation Act of 1990. The program provisions became effective on January 1, 1991. Pharmaceutical manufacturers wishing to have drugs covered under the Medicaid formulary negotiated rebates and entered into agreements with the federal government to provide Medicaid programs with a rebate on their drug products. In turn, the state Medicaid program must provide reimbursement for the entire manufacturer's covered outpatient products. The purpose of the program is to reduce costs by allowing state Medicaid programs the opportunity to receive volume discounts on purchased drugs similar to those of other large drug purchasers. In order to collect the rebates, the state submits rebate invoices to manufacturers on a quarterly basis. These invoices detail, by National Drug Code number, the number of units dispensed of each covered outpatient drug reimbursed by the Medicaid program during that quarter.

Supplemental Rebate Program

The Department negotiates and contracts for supplemental drug rebates directly with drug manufacturers. These supplemental rebates are above and beyond the rebates provided by the manufacturers under the Federal rebating program. In fiscal year 2011, the Department collected a little over \$37 million in state supplemental rebates from drug manufacturers. Currently, federal and supplemental rebates combined equate to approximately 47 percent of the Department's drug spending.

Preferred Drug List

The Department continues to develop and maintain a Preferred Drug List (PDL). Development of the PDL is based upon clinical efficacy, safety and estimated cost savings to the state. HFS continues to contract with the University of Illinois at Chicago's College of Pharmacy to perform the clinical analysis of each therapeutic class of drug under review and prepare monographs. The Drugs and Therapeutics Committee of the Illinois State Medical Society then reviews the Department's proposed PDL in each therapeutic class for clinical soundness.

For more information visit: <<http://www.hfs.illinois.gov/preferred/>>.

XIX. REIMBURSING SCHOOL BASED SERVICES

Since 1992, the School-Based Health Services program has actively participated in the Medicaid/education partnership established by the Medicare Catastrophic Coverage Act (Public Law 100-360). This partnership allows Local Education Agencies to receive Medicaid reimbursement for a portion of the costs incurred to provide direct medical services to Medicaid-enrolled children who have Individuals with Disabilities Education Act defined disabilities.

Local Education Agencies may claim Medicaid reimbursement for the following direct medical services: audiology, developmental assessments, medical equipment, diagnostic medical services, medical supplies, nursing services, occupational therapy, physical therapy, psychological services, school health aide services, social work, speech/language pathology, and transportation when the services are listed in the child's individualized education program. This program is developed cooperatively by school personnel and the parents or guardians of the child with a disability and is a legally binding agreement between the two entities.

In addition to the direct medical services, Local Education Agencies may also claim some costs for the administration of the program. Costs associated with outreach activities designed to ensure that any eligible student has access to Medicaid covered services, costs incurred for case management of the medical component of a student's Individualized Education Plan (IEP) and monitoring the delivery of necessary medical services specified in a student's IEP, are reimbursable administrative expenses.

Approximately 218,000 Illinois school children participating in the School-Based Health Services program received approximately 4.2 million units of direct medical services during fiscal year 2011. Local Education Agencies received reimbursement of more than \$103 million for their costs to provide these services and more than \$59 million for their administrative costs. In addition, the School-Based Health Services program generated more than \$1.8 million in revenue for the state.

For more information visit: <<http://www.sbhsillinois.com/>>

XX. REIMBURSING OTHER PROVIDERS

Rural Health Clinics

The RHC program, which has existed in Illinois for over 20 years, is a federally mandated program established to deliver primary health care services in rural areas that are federally designated as medically underserved. In fiscal year 2011, the RHC program had 234 sites in Illinois. This reflects an increase of five providers. RHCs are reimbursed under a Prospective Payment System (PPS). The Department establishes clinic specific all-inclusive encounter rates based on RHCs' cost reports. In fiscal year 2011, medical encounter rates for RHCs ranged from \$46.70 to \$89.97 and behavioral health encounter rates ranged from \$51.78 to \$72.41.

Federally Qualified Health Centers

FQHCs are designed to help deliver primary health care services in both urban and rural areas that are medically underserved. FQHCs receive a grant under *Section 330 of the Public Health Service Act (Public Law 787-410)*. The Health Resources and Services Administration recommend FQHC designations, which are recertified annually, to the Centers for Medicare and Medicaid (CMS). During fiscal year 2011, there were 352 FQHC sites throughout Illinois. This reflects a decrease of 5 sites from the previous fiscal year. As with RHCs, FQHCs are also reimbursed a PPS based encounter rate. In fiscal year 2011, medical encounter rates for FQHCs ranged from \$88.30 to \$133.52 and behavioral health encounter rates ranged from \$37.06 to \$56.39.

Illinois Hemophilia Program

Under the Illinois Hemophilia Program, eligible Illinois patients receive financial assistance for the cost of the antihemophilic factors, annual comprehensive medical visits and other medical expenses related to the disease. In fiscal year 2011, out of 249 enrolled participants, 129 received financial assistance for hemophilia treatment, at a cost of approximately \$17 million.

Illinois Sexual Assault Program

The Illinois Sexual Assault Program provides financial assistance to sexual assault survivors by reimbursing certified Illinois transfer centers and treatment hospitals for outpatient emergency room services provided as a result of a sexual assault. In fiscal year 2011, approximately \$1.8 million was paid for medical services provided to 833 sexual assault survivors; of which about \$1.7 million was paid for emergency hospital services and approximately \$185,000 was paid for 668 follow-up care visits.

State Chronic Renal Disease Program

The State Chronic Renal Disease Program assists patients who have been diagnosed as having End Stage Renal Disease. In order to qualify for this completely funded state program, the recipients must have applied for, but are found ineligible for benefits under Medical Assistance or All Kids. The program pays as a last resort after Medicare and private insurance. In fiscal year 2011, approximately \$573,794 was paid for 305 recipients receiving services.

Non-Emergency Transportation Services

As required by the *Social Security Act*, the Department ensures access to necessary medical care for participants enrolled under *Title XIX* (Medicaid), and *Title XXI* (SCHIP) by paying for non-emergency transportation to and from covered services for these participants. A covered service is defined as a medical service for which the Department reimburses.

The Department's Non-Emergency Transportation Services Prior Approval Program (NETSPAP) has been in place since 2001. The NETSPAP allows the Department to maintain standards and controls necessary to ensure that the payment of transportation services complies with federal requirements by ensuring that: 1) the transportation is to a covered medical service; 2) the most cost effective mode of transportation meeting the medical needs of the participant is used, and; 3) the participant is being transported to the closest appropriate medical provider.

The NETSPAP is currently administered by First Transit, Inc. First Transit is responsible for the screening of all non-emergency transportation for prior approval. In fiscal year 2011, 560,218 non-emergency transportation trips were authorized under NETSPAP compared to 538,319 non-emergency trips authorized in fiscal year 2010, an increase of 21,899 trips.

As required by *P.A. 095-0501*, HFS continues to require drivers and employee attendants of medicar and service car providers who transport participants of its Medical Assistance programs to complete a Safety Training Program approved by the HFS. To ensure compliance with the law, the Department's Office of Inspector General (OIG) conducts audits on enrolled transportation providers to review all certifications. If current certifications are not on file for drivers and attendants responsible for transporting HFS participants, the Department may recoup payments made to the transportation provider.

A current listing of approved Safety Training Programs can be found on the Department's Web site at <<http://www.hfs.illinois.gov/enrollment/>>.

XXI. QUALITY ASSURANCE, UTILIZATION AND CONTROL

Children's Health Insurance Program Reauthorization Act (CHIPRA) Child Health Quality Demonstration Grant

Illinois, in conjunction with the state of Florida, was awarded one of ten (10) CHIPRA Quality Demonstration Grants by the Centers for Medicare & Medicaid Services (CMS). CHIPRA authorized the CMS to award grants to states to experiment with and evaluate promising ideas for improving the quality of children's health care under Medicaid and the Children's Health Insurance Program (CHIP), with the goal of establishing a pediatric measurement program by 2013 by assimilating information learned from the CHIPRA quality demonstration projects. Illinois and Florida were selected to perform work in four of five categories as established by CMS in the Grant Request for Proposals. From 2010 to 2015, the grant funds in Illinois and Florida will support activities to:

- Experiment with and evaluate the use of quality measures for children's health care (Category A);
- Promote the use of Health Information Technology in measuring and improving children's health (Category B);
- Support and evaluate innovative, provider-based models (medical homes) for delivering children's health care (Category C); and
- Implement a quality improvement collaborative focused on improving perinatal and early childhood care (Category E).

While 2010 was devoted to planning, considerable progress was made during 2011. In Category A, the Department reported to CMS on 17 of the 24 core measures. CMS has determined that Grantee states are not required to report on 2 of the measures until revised specifications are available. One of the measures requires a change to the Primary Care Case Management contract, which was not feasible during 2011. The remaining 4 measures are being programmed.

Category B work focused on coordinating efforts with the Governor's Office of Health Information Technology and communicating needs for clinical data collection for measure reporting and functionality for purposes of care coordination. Category B work is expected to progress more quickly in 2012 when features of the Health Information Exchange become operational.

The medical home initiative focused on recruitment during 2011 with over 60 practices committed to participate. The Illinois Chapter of the American Academy of Pediatrics is leading this component of the CHIPRA grant. In 2012, a menu of services (webinars, technical support, peer learning opportunities, quality improvement initiatives, and other resources) will be made available to participating practices to assist them in adopting medical home components.

In Category E, a Prenatal Electronic Data Set was developed, which will be used to share information among prenatal providers, including delivery hospitals, to improve care coordination. In 2012, the Prenatal Electronic Data Set will be submitted to the Illinois Health Information Exchange for consideration as a "use case". Work also began to develop a set of Minimum Quality Standards for Prenatal Care, based on American College of Obstetrics and Gynecology guidelines, and is intended to be a tool for prenatal care providers. Expert stakeholder input was in developing these quality tools.

Managed Care - External Quality Review Organization

The Department is federally required to contract with an External Quality Review Organization (EQRO), as defined in *42 CFR Part 438 Subpart E*. The EQRO provides quality assurance oversight of MCOs.

As a result of a competitive procurement, the Department entered into a contract with Health Services Advisory Group (HSAG) beginning June 1, 2006, and ending May 31, 2009. HFS executed its second renewal with HSAG through May 31, 2011, and then extended the contract initially through a sole source and subsequently through an emergency extension ending on December 31, 2012. The Department is currently in the process of finalizing a Request for Proposals to secure a new EQRO contract.

HSAG provides the federally required, External Quality Review (EQR) activities, as well as technical assistance, to the MCOs under contract with the Department. This includes three contracted MCOs for Voluntary Managed Care Program and two contracted MCOs contracted for the Integrated Care Program. The EQRO annually performs an external quality review including the mandatory activities using CMS protocols. The areas reviewed include:

- Quality Assurance Plan Compliance Review;
- Validation of Performance Measures;
- Validation of Performance Improvement Projects;
- Overall Evaluation of the Quality Strategy; and
- Technical Assistance on Quality Assurance Monitoring to MCOs and the Department, at the direction of the Department.

State Quality Strategy for Managed Care

As federally required, the HFS developed a written strategy for assessing and improving the quality of Medicaid MCOs and prepaid inpatient health plan services. The MCO State Quality Strategy was developed with input from stakeholders, including provider groups, advocates, MCOs and the Department. The quality strategy was reviewed by the Centers for Medicare and Medicaid Services (CMS) who offered valuable feedback. The Department is in the process of updating the MCO State Quality Strategy to include integrated care and expand on performance goals, measurable targets, and satisfactory progress toward those targets. As contractually required, HSAG will perform an EQR to assess the completeness of the updated MCO State Quality Strategy.

EQR Technical Report

HSAG provided the Department with their 2009-2010 EQR Technical Report and will provide their 2010-2011 EQR Technical Report describing the manner in which data from external quality review activities were aggregated and analyzed. The technical report focuses on the three federally mandated external quality review activities: 1) compliance monitoring evaluation; 2) validation of performance measures; and 3) validation of performance improvement projects. The EQR Technical Report focuses on an analysis of each MCO's performance in the area of quality assurance and quality monitoring and identifies recommendations for improvement. Previous reports are available on the Department's Web site at:

<http://www.hfs.illinois.gov/managedcare/eqtr.html>

Emergency Department Diversion Program

On April 14, 2008, the Department was awarded a grant made under the authority of *Section 6043 of the Deficit Reduction Act of 2005* via funding through DHS/CMS. As a result of the grant process, the Department entered into grant agreements with

Heartland Community Health Clinic (Peoria County) and Access Community Health (Cook County). Under these grants each entity established pilot programs with collaborations within their counties to provide alternatives to emergency department care for persons seeking care for either non-emergent medical or mental health conditions, and using a peer-staffed and recovery focused approach in the mental health service intervention. In addition, the collaborations educated eligible enrollees on the importance of their medical home, directed enrollees with medical homes back to their PCP for primary and preventive services and connected the enrollees with the IHC or Illinois Client Enrollment Broker help lines for assistance in selecting a medical home or changing their medical home if needed.

The demonstration ended in April of 2011. The final report was submitted to the Federal CMS in July of 2011. While neither demonstration proved to be an all around success, both entities reported invaluable lessons learned and promising practices developed, including better methods to integrate behavioral health care with primary care, identifying pathways that can divert people from the Emergency Department when appropriate, and incorporating peer support and other recovery-oriented services. The grant reinforced their commitment to being an active participant in changing the way that health care services are delivered.

Quality Improvement Organization

State Medicaid agencies are required to provide utilization review and quality assurance in the inpatient hospital setting for services provided to the fee-for-service participants in the Medical Assistance program. HFS contracts with eQHealth Solutions, formerly known as HealthSystems of Illinois, a federally designated quality improvement organization, to assist in providing these services. eQHealth participates in several quality studies and initiatives designed to identify issues of concern, improve quality of care, and make recommendations on implementation of strategies to improve outcomes. The utilization review services and quality assurance studies eQHealth performs under its contract with HFS are eligible for an enhanced federal match rate of 75 percent.

During fiscal year 2011, non-certification of medically unnecessary services resulted in direct cost savings of approximately \$23 million; for an estimated cumulative savings of \$214 million since fiscal year 2002. The return on investment is estimated at \$3.00 saved for every dollar invested, in addition to providing quality of care reviews to assure that professional recognized standards are met. The following types of utilization reviews are performed:

- Concurrent Review – review conducted by telephone or a secured Web review system while the patient is hospitalized.
- Prepayment Review – Retrospective medical record review conducted after discharge and prior to HFS paying the hospital.
- Post-payment Review – Retrospective medical record review for a sample of defined categories of hospitalizations conducted after discharge and after the hospital has been reimbursed.

Review Activity

In fiscal year 2011 eQHealth conducted:

- 243,204 concurrent and retrospective reviews associated with 133,606 hospitalizations.
- 18,727 reviews on children's mental health hospitalizations which represented 16 percent of the total hospitalizations reviewed. Children's mental health hospitalizations were associated with 220,625 acute care days.

The QIO contractor also performs quality of care screening for all psychiatric hospitalizations and all medical/surgical hospitalizations subject to concurrent review. In addition, a quality of care review is performed on all prepayment and post-payment reviews to ensure quality of services provided met professionally recognized standards of health care. In fiscal year 2011, 15 percent of all physician referrals resulted in medical necessity denials. The overall denial rate decreased by two percentage points; which was mainly influenced by a decline in the medical/surgical and detoxification clinical areas. The largest increase was seen in adult and child behavioral health clinical services, which has been the case in previous reporting periods.

Special Report Activity

During fiscal year 2011, 18 special studies and ad hoc data analyses were conducted to assist HFS in making informed program decisions. A new Neonatal Intensive Care database was rolled out, and changes were implemented for several voice and data systems to increase stability and security. In addition, eQHealth developed and conducted provider updates/informational notices, implemented a comprehensive user guide for a new electronic review system, and developed a 'Quick Guide' for shortened DRG Web review processes.

Long Term Acute Care (LTAC) Hospital Quality Improvement Transfer Act of 2010 — P. A.96-1130

The LTAC Act presented a unique opportunity for HFS and eQHealth Solutions to collaborate on a new and original affiliation. eQHealth successfully implemented the Act by designing a comprehensive program focused on quality, methodology, monitoring, and assessments, including tool kits and studies. To participate in the program, a hospital must apply to HFS and meet specific criteria to become qualified as a LTAC facility. Nine facilities have been certified as LTAC hospitals since the implementation of the Act.

HCBS Waiver Program Oversight, Monitoring, and Administrative Coordination

HFS, as the single state Medicaid agency, plays a critical role in developing quality improvement systems that effectively address the health and welfare of individuals in Illinois' HCBS waiver programs. The Department's goal is to maximize the quality of life, functional independence, health, and well being of this population through ongoing monitoring, data analysis and systems improvements. To continuously achieve this goal, HFS works in partnership with our operating agencies and federal CMS to oversee the design and implementation of each waiver's quality improvement system.

In response to a 2003 General Accountability Office (GAO) report titled, "Long Term Care: Federal Oversight of HCBS Waivers Should be Strengthened", CMS designed and adopted an evidence-based approach to HCBS waiver program quality. States must provide CMS with evidence that each waiver is operating as specified in the approved application and that the participants' health and welfare are protected. CMS requires that states have continuous quality improvement systems.

During the waiver renewal process, federal CMS reviews each waiver's quality improvement system to determine whether it meets federal requirements. As the Medicaid agency, CMS expects that HFS has processes in place to monitor every function that is delegated to the waiver operating agencies.

Throughout fiscal year 2011, CMS has required more intensive data collection, analysis, and quality assurance reporting. Performance measures are now required for each federal assurance and sub-assurance resulting in an average performance

measure range of 35-45 measures per waiver. CMS expects 100 percent compliance and when the compliance level is below 100 percent, individual case remediation is required. The new CMS expectations have been challenging for both HFS and its operating agencies, as new monitoring and reporting systems have been developed or are still under development.

In addition to routine oversight activities, HFS continued to work with eQHealth to assure that they meet their contract expectations for HCBS quality oversight and special projects. During 2011, eQHealth provided assistance with onsite and record reviews to monitor health, safety, and welfare for five of the eight HCBS waiver operated by sister-agencies. eQHealth does not monitor the two waivers for Children with Developmental Disabilities or the Supportive Living Facilities waiver. These programs are monitored directly by HFS and the Division of Developmental Disabilities (for the children's programs).

In addition, during fiscal year 2011, eQHealth conducted a special project for the Department and developed an Interdisciplinary Team (IDT) process and protocol to be used for persons transitioning out of the waiver for children who are medically fragile, technology dependent and into the waiver for persons with disabilities. A uniform medical and functional review was developed for use by the IDT. The process was tested on a pilot basis during this period and revisions were made based on feedback from the IDT members. The IDT members were staff from HFS, DSCC, and DRS. An independent contractor facilitated the process. The purpose was to ensure that those transitioning receive services and supports that meet their daily living and medical needs.

Third Party Liability Program

The Third Party Liability (TPL) program reduces costs in the Medical Assistance Program by identifying third parties liable for payment of enrollees' medical expenses. These efforts help the Department maintain a full range of covered medical services and help ensure access to quality healthcare for enrollees. Third party resources include, private health insurance, Medicare, Civilian Health and Medical Plan for the Uniformed Services, worker's compensation and estate and tort recoveries.

The Department requires individuals to report TPL coverage when applying for Medical Assistance as a condition of eligibility. Although one of the primary sources of TPL identification is through client interviews during the intake and redetermination processes, the Department also identifies potential third party resources through a variety of methods, including contacting employers and absent relatives, through data exchanges with health insurance carriers, review of court dockets and data exchanges with the Illinois Industrial Commission. The Department also requires medical providers to bill third parties prior to billing the Department for most services (cost avoidance), and assists enrollees in coordinating benefits between their private health insurance coverage and Medical.

The TPL program saved taxpayers approximately \$1.7 billion in Medicaid cost during fiscal years 2009, 2010, and 2011: \$513.9 million in fiscal year 2009; \$567 million in fiscal year 2010 and; \$623.4 million in fiscal year 2011. These savings resulted from identification of third party resources, avoidance of payments on claims with a known responsible third party, benefit recovery efforts through subrogation of paid claims, and estate and tort action collections. The Department works to maximize TPL utilization and to integrate TPL recovery with the managed care program.

The Health Insurance Premium Program, a component of the TPL program, pays cost effective health insurance premiums for Medicaid enrollees with high cost medical conditions, which reduces costs to the Medical Assistance Program. Pregnancy was

the most frequent high cost medical condition for which premiums were paid. Many enrollees in this program continue their health coverage through the Consolidated Omnibus Reconciliation Act when their employment terminates rather than applying for traditional Medicaid.

Program Integrity Function

The Office of Inspector General (OIG) monitors payments made under the Medical Assistance program and helps to ensure that the Department conforms to the federal requirements necessary to receive federal matching funds. By systematically monitoring the provision and use of medical services, the OIG is able to implement corrective action when a problem is identified. The Department's Surveillance and Utilization Review Subsystem creates profiles of Medicaid providers' billing practices and recipient medical services. Establishing norms within similar demographic areas generates these profiles. Provider and recipient profiling and referrals from outside sources, such as the Welfare/Medicaid Fraud Hotline, serve as the foundation for the Office's evaluation process to identify subsequent action. Actions that may be implemented include:

- Conducting peer reviews of medical providers to determine if quality care is being provided. Termination or suspension from participation in the Medical Assistance program can occur if the provider renders poor quality of care as determined by their peer group;
- Conducting post-payment compliance audits of medical providers and recovering monies found to be improperly paid. Serious violations may result in terminating the provider from participation in Medicaid and/or a referral to the Illinois State Police Medicaid Fraud Control Unit; and
- Restricting individuals who over utilize Medicaid services to a primary care physician and/or pharmacy for 12 to 24 months.

In fiscal year 2011, the Department completed peer reviews on 173 providers and audited 293 providers. The Department terminated 70 providers and suspended three providers from participation in the Medical Assistance Program. There were two additional providers who voluntarily withdrew to avoid disciplinary action.

There were 94 providers that were notified to initiate corrective actions measures to improve selected areas of their practice. Overpayments totaling \$9.4 million were collected due to provider audits. Restitution accounted for a little over \$200,000. In addition during fiscal year 2011, there were 516 new recipients restricted to a primary care physician and/or pharmacy.

In fiscal year 2010, the Department completed peer reviews on 209 providers and audited 292 providers. The Department terminated 40 providers and suspended three providers from participation in the Medical Assistance Program. There were an additional eight providers who voluntarily withdrew to avoid disciplinary action. There were 134 providers that were notified to initiate corrective actions measures to improve selected areas of their practice. Overpayments totaling \$10,679,406 were collected due to provider audits. Restitution accounted for \$250,153. In addition during this fiscal year, there were 469 new recipients restricted to a primary care physician and/or pharmacy.

In fiscal year 2009, the Department completed peer reviews on 199 providers and audited 159 providers. The Department terminated 33 providers and suspended 3 providers from participation in the Medical Assistance Program. There were an additional 2 providers who voluntarily withdrew to avoid disciplinary action. There were 98 providers that were notified to initiate corrective actions measures to improve

selected areas of their practice. Overpayments totaling \$26,216,807 were collected due to provider audits. Restitution accounted for \$138,494. In addition during this fiscal year, there were 339 new recipients restricted to a primary care physician and/or pharmacy.

XXII. ACRONYMS

AABD	Aid to the Aged, Blind and Disabled
AARP	Association of American Retired Persons
ADRC	Aging and Disability Resource Center
AKAA	All Kids Application Agents
ARRA	American Reinvestment and Recovery Act
AVRS	Automated Voice Response System
AWP	Average Wholesale Price
BPRA	Bureau of Program and Reimbursement Analysis
BSFB	Bright Smiles from Birth
CC	Care Coordination
CCE	Care Coordination Entity
CCMN	Children with Complex Medical Needs
CHAP	Critical Hospital Adjustment Payment
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DCFS	Department of Children and Family Services
DD	Developmental Disabilities
DHS	Department of Human Services
DHS-DDD	Department of Human Services—Division of Developmental Disabilities
DHS-DRS	Department of Human Services—Division of Rehabilitation Services
DHS-DMH	Department of Human Services—Division of Mental Health
DoA	Department on Aging
DPH	Department of Public Health
DSCC	Division of Specialized Care for Children
DSH	Disproportionate Share Hospitals
ECC	Electronic Claims Capture
ECP	Electronic Claims Processing
EDW	Enterprise Data Warehouse
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FAQ	Frequently Asked Questions
FFY	Federal Fiscal Year
FY	Fiscal Year
FMAP	Federal Medical Assistance Percentages
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GRF	General Revenue Fund
HBWD	Health Benefits for Workers with Disabilities
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HFS	Healthcare and Family Services
HHS	US Department of Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HME	Home Medical Equipment
HMO	Health Maintenance Organization

HSAG	Health Services Advisory Group
ICAAP	Illinois Chapter of the American Academy of Pediatrics
ICF/DD	Intermediate Care Facility/Developmental Disabilities
ICP	Integrated Care Plan
ICRx	Illinois Cares Rx
IEP	Individualized Education Plan
IHC	Illinois Health Connect
IHW	Illinois Healthy Women
MAC	Maximum Allowable Cost
MCCN	Managed Care Community Networks
MCO	Managed Care Organization
MDS	Minimum Data Set
MEDI	Medical Electronic Data Interchange
MFP	Money Follows the Person
MFTD	Medically Fragile Technology Dependent
MHVA	Medicaid High Volume Adjustment Payment
MMIS	Medicaid Management Information System
MPA	Medicaid Percentage Adjustment
NETSPAP	Non-Emergency Transportation Services Prior Approval Program
NF	Nursing Facility
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
P4P	Pay for Performance
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDL	Preferred Drug List
PIAP	Pediatric Inpatient Adjustment Program
PPS	Prospective Payment System
REV	Recipient Eligibility Verification
RHC	Rural Health Clinic
SASS	Screening, Assessment and Support Services
SCHIP	State Children's Health Insurance Plan
SLF	Supportive Living Facility
SNAP	Safety Net Adjustment Payment
SPD	Seniors and Persons with Disabilities
SPOE	Single Point of Entry
TAG	Technical Advisory Group
TPL	Third Party Liability

XXIII. APPENDICES

Appendix A – Eligibility Groups and Program Descriptions

Aid to Aged Blind and Disabled (AABD) Medical covers seniors, persons who are blind and persons with disabilities with income up to 100 percent of the federal poverty level (FPL) and no more than \$2,000 of non-exempt assets (one person). Federal matching funds are available under Medicaid for these individuals. More information on how to apply for these programs may be found on the Department of Human Services Web site at:

<http://www.dhs.state.il.us/page.aspx?item=33698>

DCFS – Coverage is provided to children whose care is subsidized by DCFS under Title IV-E (Child Welfare) of the Social Security Act as well as children served by DCFS through its subsidized guardianship and adoption assistance programs. Federal matching funds are available under Medicaid for nearly all of these children. More information on DCFS programs may be found at www.state.il.us/dcfs/index.shtml.

Family Health Plans

The All Kids and FamilyCare programs are comprised of five plans. At the end of fiscal year 2011, about 2.4 million children and their parents were covered by one of the All Kids and FamilyCare plans. Children are eligible through 18 years of age. Adults must be either a parent or caretaker relative with a child under 19 years of age living in their home. For all plans, adults must live in Illinois and be U.S. citizens or legal permanent immigrants in the country for a minimum of five years. Children and pregnant women must live in Illinois and are eligible regardless of citizenship or immigration status. For more information visit: <http://www.allkids.com> and <http://familycareillinois.com/>

The All Kids Web site is maintained to provide easily accessible and current information about the program. Families may apply online through both an English and Spanish Web-based application. Both English and Spanish applications are also available for download by persons who want to apply for All Kids by mail. Those using the Web site may also ask questions about the program. Information is provided about income guidelines, cost sharing, and All Kids Application Agents (AKAAs). AKAAs continue to be a successful component of the overall outreach program. As of June 30, 2011, there were 753 active AKAAs sites throughout Illinois, where families could receive assistance. The AKAAs have a strong approval rating for applications they submit to All Kids. In fiscal year 2011, the approval rating of AKAAs applications was 91 percent.

FamilyCare/All Kids Assist provides a full range of health benefits to eligible children 18 years of age and younger, and their parents or caretaker relatives. To be eligible, individuals must have countable family income within 133 percent of the FPL (\$2,477 per month for a family of four). Children covered under All Kids Assist have no co-payments or premiums. FamilyCare Assist parents have co-payments of \$3 or less per medical service or prescription received.

FamilyCare/All Kids Share provides a full range of health benefits to eligible children, parents or caretaker relatives. To be eligible, families must have countable family income over 133 percent and at or below 150 percent of the FPL (between \$2,478 and \$2,794 a month for a family of four). Adults in

families with access to health insurance coverage for state employees are not eligible for FamilyCare Share.

Children in All Kids/FamilyCare Share have a \$2 co-payment for each medical service and prescription received, up to a maximum of \$100 per family per year. There are no co-payments for well-child visits and immunizations.

FamilyCare Share parents have co-payments of \$3 or less per medical service or prescription received. Families with members who are American Indians or Alaska Natives do not pay premiums or co-payments.

FamilyCare/All Kids Premium Level 1 provides a full range of health benefits to eligible children, parents or caretaker relatives. For children to be eligible, families must have countable income over 150 percent and at or below 200 percent of the FPL (between \$2,795 and \$3,725 a month for a family of four). For parents and caretaker relatives to be eligible, families must have countable income over 150 percent and at or below 185 percent of the FPL (between \$2,795 and \$3,446).

Families eligible for FamilyCare/All Kids Premium Level 1 pay monthly premiums of \$15 for one family member, \$25 for two family members, \$30 for three, \$35 for four, and \$40 for five or more. All Kids Premium Level 1 children have a \$3 or \$5 co-payment for each medical service or prescription received, up to a maximum of \$100 per family per year.

There are no co-payments for well-child visits and immunizations. FamilyCare Premium Level 1 parents have co-payments of \$3 or less per medical service or prescription received. Families with children who are American Indians or Alaska Natives do not pay premiums or co-payments.

All Kids Premium Level 2 provides a full range of health benefits to eligible children in families with income above 200 percent and at or below 300 percent of the FPL (between \$3,726 and \$5,588). Monthly premiums are \$40 for one child and \$80 for two or more children. Co-payments vary by service. For example, the copayments for physician visits are \$10, prescriptions are \$3 and \$7 and hospital inpatient is \$100 per admission.

All Kids Premium Levels 3 through 8 provide a full range of health benefits to eligible children in families with income above 300 percent of the FPL. There is no upper income limit. The family's cost sharing, in the form of premiums and co-payments, increases as their income rises. Monthly premiums range from \$70 to \$300 per child depending on the family's income. Co-payments vary by service, and are also based on family income. For example, the co-payment for a physician visit ranges from \$15 to \$25. New enrollment in All Kids Premium Levels 3 through 8 ended on July 1, 2011. Coverage for any children enrolled in All Kids Premium Levels 3 through 8 will cease at the end of fiscal year 2012 per P.A. 096-1501.

All Kids/FamilyCare Rebate provides families with full or partial reimbursement of premium costs, up to \$75 per person per month, for private or employer-sponsored health insurance coverage of eligible family members. To be eligible, families must have countable family income over 133 percent and at or below 200 percent of the FPL (between \$2,478 and \$3,725 a month for a family of four). To qualify, they must have health insurance that covers physician and inpatient hospital care. Co-payments and premiums for All Kids/FamilyCare Rebate families are determined by the requirements of the family's private health insurance.

Moms and Babies provides a full range of health benefits to eligible pregnant women and their babies up to one year of age. To be eligible, pregnant women must have countable family income at or below 200 percent of the FPL (at or below \$3,725 a month for a family of four). Babies under one year of age are eligible at any income as long as Medicaid covered their mother at the time of the child's birth. Moms and Babies enrollees have no co-payments or premiums and must live in Illinois.

Health Benefits for Persons with Breast or Cervical Cancer¹ (BCC) covers uninsured women at any income level who need treatment for breast or cervical cancer. Beginning October 1, 2007, the program was expanded to provide screening and coverage for treatment to all uninsured women regardless of income, making Illinois the first state to ensure all women who need access to screening and treatment are afforded those services.

From fiscal year 2007 through fiscal year 2011, 3,843 women were approved for the BCC program. Federal matching funds, at the enhanced rate of 65 percent, are available under Medicaid for women with income up to 200 percent of the FPL. Under the program, the Department of Public Health provides screenings for breast and cervical cancer. The Department administers the treatment portion of the program. Individuals who are not enrolled in BCC should call the DPH Women's Health Line 1-888-522-1282 (1-800-547-0466 TTY). The Women's Health Line will be able to walk women through the eligibility requirements and the screening process. Those who are already receiving coverage under the treatment portion of the program may call the Department's BCC Unit at 1-866-460-0913 (1-877-204-1012 TTY).

The Breast Cancer Quality Screening and Treatment Initiative (BCQSTI) is a partnership between the Illinois Department of Healthcare and Family Services and the Department of Public Health. To help ensure that women in all communities have access to high quality mammograms and breast cancer information, the State has appointed the Breast Cancer Quality Screening and Treatment Board. The board was created as a result of Public Act 095-1045 and began meeting every six to eight weeks on December 3, 2010. For additional information, visit

<http://www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommissions/BCQSTI/Pages/default.aspx>

Health Benefits for Workers with Disabilities (HBWD) covers persons with disabilities who work and have earnings up to 350 percent of the FPL who buy-in to Medicaid by paying a small monthly premium. Eligible people may have up to \$25,000 in non-exempt assets. Retirement accounts and medical savings accounts are exempt. Federal matching funds are available under Medicaid for these benefits.

During fiscal year 2011, HBWD provided health coverage to a monthly average of 820 employed people. Throughout the year HBWD staff distributed more than 1,144 applications and through attendance at conferences, seminars and training sessions, HBWD staffs educate Illinois citizens about the benefits of the program. Comprehensive program information, as well as a downloadable application can be found at <www.hbwdillinois.com>

¹ Services are specific to program and do not cover a comprehensive array of health services.

Illinois Cares Rx Program (formerly SeniorCare and Circuit Breaker Pharmaceutical Assistance)¹ provides prescription drug coverage to senior and disabled individuals not eligible for Medicaid whose annual income is no more than \$27,610 for a household of one, \$36,635 for a household of two, or \$45,657 for a household of three or more, regardless of assets.

In fiscal year 2011, Illinois Cares Rx (ICRx) provided coverage to approximately 208,000 participants. The vast majority of ICRx members are Medicare-eligible. ICRx provides a \$25 rebate, in lieu of prescription drug coverage, to members who have drug coverage through the Veterans Administration, or private insurance, or are enrolled in a Medicare Part D plan that does not coordinate with ICRx. Individuals may learn more or apply online at www.illinoiscaresrx.com.

Illinois Healthy Women (IHW) Program¹ is a special Medicaid waiver program that provides family planning (birth control) services to low-income women who qualify. Federal matching funds are available at the 90 percent enhanced rate for family planning services.

Through June 30, 2011 an unduplicated total of 132,603 women had received family planning services through Illinois Healthy Women. Individuals may learn more or download an application at: www.Illinoishealthywomen.com

Medicare Cost Sharing covers the cost of Medicare Part B premiums, coinsurance, and deductibles for Qualified Medicare Beneficiaries (QMB) with incomes up to 100 percent of the FPL. Medicare cost sharing covers only the cost of Medicare Part B premiums only for persons with incomes over 100 percent of the FPL but less than 135 percent of the FPL under the Specified Low-Income Medicare Beneficiaries (SLIB) or Qualifying Individuals (QI) programs. Assets are limited to \$6,680 for a single person and \$10,020 for a couple. The federal government shares in the cost of this coverage.

Pay-In Spenddown provides individuals whose income and/or assets are too high for regular Medicaid to enroll and pay their spenddown amount to the Department, rather than having to accumulate bills and receipts of medical expenses on a monthly basis and provide them to the DHS FCRC. After enrolling in the Pay-In program, monthly statements of the spenddown amount are issued to the client providing the opportunity to meet spenddown through money order, cashier's check, debit or credit card payment.

For fiscal year 2011, 4,404 new individuals had enrolled in Pay-in Spenddown Program, bringing total enrollment to 20,909. In fiscal year 2011 these individuals made 11,580 payments totaling approximately \$1.5 million toward their spenddown amounts. Additional information on the Pay-In program can be found at: www.hfs.illinois.gov/medicalbrochures/hfs591sp.html

State Hemophilia Program¹ provides assistance to eligible patients to obtain antihemophilic factor, annual comprehensive visits and other outpatient medical expenses related to the disease. Participants must complete a financial application each fiscal year. Some participants may be responsible for paying a participation fee prior to the program paying for eligible medications. Participation fees are determined by the individual's family income and family size, and are similar to an annual insurance deductible. The program is always the payer of last resort, meaning that it only pays after

¹ Services are specific to program and do not cover a comprehensive array of health services.

other third party payers, such as private insurance or Medicare, have made a benefit determination. The program is available to any non-Medicaid eligible resident of Illinois with a bleeding or clotting disorder. Additional information about the State Hemophilia Program can be found at: www.hfs.illinois.gov/handbooks/chapter100.html

State Renal Dialysis Program¹ covers the cost of renal dialysis services for eligible persons who have chronic renal failure and are not eligible for coverage under Medicaid or Medicare. Eligibility for the program is reviewed and determined on an annual basis. Participants must be a resident of Illinois, and meet citizenship requirements. The program assists eligible patients who require lifesaving care and treatment for chronic renal disease, but who are unable to pay for the necessary services on a continuing basis. The program covers treatment in a dialysis facility, treatment in an outpatient hospital setting and home dialysis, including patients residing in a long-term care facility. Individuals determined eligible for the program may be responsible for paying a monthly participation fee based on family income, medical expenses and liabilities, family members, and other contributing factors. All participation fees are paid directly to the dialysis center that provided the treatment. These benefits are financed entirely with state funds. Individuals may learn more or download an application at: www.hfs.illinois.gov/renalprogram/

State Sexual Assault Survivors Emergency Treatment Program¹ pays emergency outpatient medical expenses and 90 days of related follow-up medical care for survivors of sexual assault. The program will reimburse an Illinois hospital for a patient's initial emergency room (ER) visit and for related follow-up care for 90 days following the initial ER visit. If the patient receives a voucher at the hospital for the program's follow-up program, then the patient can seek their 90 days of follow-up care from the community providers of their choosing. The Department maintains an on-line registry for hospitals to register the sexual assault survivor in order to produce a voucher that allows the survivor to obtain needed follow-up care outside of an Illinois hospital. The program is always the payer of last resort, meaning that it only pays after other third party payers, such as private insurance or Medicare, have made a benefit determination. Participants currently eligible for Medicaid are not eligible to receive benefits under this program. Additional information about this program can be found at: www.hfs.illinois.gov/handbooks/chapter100.html

Veterans Care provides comprehensive healthcare to uninsured veterans under age 65 who were honorably discharged from the military, are income eligible, and are not eligible for federal healthcare through the U.S Veterans Administration. Eligible individuals pay a monthly premium of either \$40 or \$70 depending on their income. By the end of fiscal year 2011, 754 Illinois veterans had been approved for coverage at an average monthly premium of \$40. Veterans may apply for Veterans Care by either downloading an application from the web site, or by going to their local Illinois Department of Veterans Affairs Office. The Department of Healthcare and Family Services determines eligibility, notifies the Veteran and handles the premium payments. More information about Veterans Care is available at: www.illinoisveteranscare.com/

¹ Services are specific to program and do not cover a comprehensive array of health services.

Refugee Program covers persons who are not citizens and who are not otherwise qualified aliens, but who are admitted to the U.S. as refugees, asylees or conditional entrants; resident non-citizens who were formerly refugees; certain Amerasian immigrants from Vietnam; certain Cubans and Haitians; or victims of human trafficking.

Transitional Assistance (City of Chicago)¹ provides limited outpatient services to very low-income persons (income less than 30 percent of poverty) living in Chicago who are not otherwise eligible.

Medical Assistance for Asylum Applicants and Torture Victims provides up to 24 months coverage for persons who are not qualified immigrants but who are applicants for asylum in the U.S. or who are non-citizen victims of torture receiving treatment at a federal funded torture treatment center. Such person must meet all other eligibility criteria.

¹ Services are specific to program and do not cover a comprehensive array of health services.

Appendix B - Overview of HCBS Waiver Programs

A description of the Department's nine HCBS waivers is provided below.

Medically Fragile, Technology Dependent (MFTD) Children Waiver

The MFTD waiver for children serves persons, less than 21 years of age, allowing them to remain in their homes rather than being placed in institutional care. Parental income is waived (or not considered) when determining financial eligibility for Medicaid. Cost-effectiveness for eligibility is also compared to service costs in a hospital or a nursing facility. The waiver was initially approved in 1985 for 50 children and is currently approved for the period of September 1, 2007, through August 31, 2012, with a capacity of up to 700 children. During federal fiscal year 2011, 606 unduplicated children, were served under the waiver.

The primary expenditure under the MFTD waiver is for skilled nursing, which is available as a non-waiver service since the children served by the waiver are afforded the same extent of medical coverage provided to children receiving medical assistance. Services available only under the waiver include respite, environmental modifications, nurse training, family training, placement maintenance counseling, and special medical equipment and supplies not covered by the Medicaid program.

The Department maintains the administrative oversight of the waiver program, and the University of Illinois, Division of Specialized Care for Children (DSCC) is responsible for the day-to-day operations. Funding for the waiver is appropriated to the Department which determines waiver eligibility and approves the plans of care prior to the children receiving services. DSCC provides case coordination, processes claims for nursing payments, conducts utilization review, and monitors delivery of the waiver services. Medical eligibility for the waiver is determined by an objective Level of Care screening tool, implemented in March of 2009. To be eligible for the MFTD waiver, the child must have 50 points on the tool. Scoring is based on medical fragility and medical technology. The Department continues to work on a comprehensive assessment and rule changes related to the assessment.

During this period, HFS received a draft CMS management report with recommendations for improved quality management systems, including the addition of performance measures and the implementation of monitoring using a statistically valid sample. HFS has been working towards meeting the CMS expectations as the waiver renewal gets closer.

Adults with Developmental Disabilities Waiver

This HCBS waiver serves individuals with developmental disabilities who are 18 years of age or older. The waiver allows participants to receive services and remain in their homes or home-like community residential settings rather than being placed in an ICF/DD. The Department of Human Services, Division of Developmental Disabilities (DHS-DDD) is the operating agency for this waiver. The waiver for adults with developmental disabilities was initially approved in 1983. In July 1999, CMS approved a replacement waiver. The waiver was renewed effective July 1, 2007 through June 30, 2012. In fiscal year 2011, the Department received the final federal CMS Management Review report. DDD and HFS have begun implementing the new performance measures that were developed as a result of the CMS' review. During federal fiscal year 2011, 17,401 individuals received services under the waiver.

Children and Young Adults with Developmental Disabilities -Support Waiver

The children's support waiver serves children with developmental disabilities between 3 and 22 years of age, residing in their family homes. Services include: personal support; assistive technology; behavior intervention and treatment; adaptive equipment; home accessibility modifications; vehicle modifications; training and counseling services for unpaid caregiver; and service facilitation. Like the adult waiver, the children must also be at risk for ICF/DD level of care without the support of the waiver. Family income is waived when determining Medicaid eligibility.

When this waiver was approved in July 2010, CMS required that the Department to make major changes to the Quality Improvement sections of the waiver. Specifically CMS required that the state use a statistically valid and representative sample for waiver monitoring and that performance measures be in place for every function, including all functions that are delegated to the Operating agency. CMS also required HFS to submit quarterly progress reports to report on the progress of implementing new policies and procedures related to grievances, complaints and incident reporting systems. CMS approved the waiver renewal, effective July 1, 2010 to June 30, 2015. Later in that year, an amendment was approved to increase the waiver capacity from 1,300 to 1,400. In federal fiscal year 2011, 1,380 persons were served in the waiver.

Children and Young Adults with Developmental Disabilities – Residential Waiver

The children's residential waiver provides services to children with developmental disabilities between 3 and 22 years of age, living in group homes licensed by Department of Children and Family Services. Services include: residential habilitation, including child group homes for ten or fewer persons; assistive technology; behavior intervention and treatment; and adaptive equipment. These children must also be at risk for ICF/DD level of care without the support of the waiver. This waiver, like the MFTD and the children's support waiver, also waives family income when determining Medicaid eligibility.

When this waiver was renewed in July 2010, CMS required that the Department make major changes to the Quality Improvement sections of the waiver. Specifically, CMS required that the state use a statistically valid and representative sample for waiver monitoring and that performance measures be in place for every function, including all functions that are delegated to the Operating agency. CMS also required HFS to submit quarterly progress reports to report on the progress of implementing new policies and procedures related to grievances, complaints and incident reporting systems. CMS approved the waiver renewal, effective July 1, 2010 to June 30, 2015. During federal fiscal year 2011, 273 persons were served.

Persons with Brain Injury Waiver

The HCBS waiver for persons with brain injury serves individuals of any age who have been diagnosed with an acquired brain injury and who would require a nursing home level of care. With an array of special services, the waiver allows participants to remain in their homes and communities.

On May 6, 2011, HFS received the final federal CMS Management Review report. The State has been working with federal CMS consultants on performance measures and other quality improvement strategies. The waiver was renewed for five years beginning July 1, 2007 and is effective until June 30, 2012. During federal fiscal year 2011, 4,771 persons were served.

Persons with HIV/AIDS Waiver

This HCBS waiver serves individuals diagnosed with Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (HIV/AIDS) who are eligible for nursing facility level of care but wish to remain in their homes and receive services. The waiver is operated by the DHS-DRS Home Services Program and was initially approved in October 1990. During federal fiscal year 2011, there were 1,405 persons served.

Persons with Physical Disabilities Waiver

The Persons with disabilities waiver provides services to individuals under 60 years of age with disabilities who would qualify for the level of care in a nursing home. Services are also provided to those persons over 60 years of age who were determined eligible prior to their 60th birthday and wish to remain in the program. Otherwise, waiver participants have the option of moving to the HCBS waiver for the elderly after 60 years of age. Under the waiver, special services are provided that allows participants to remain in their homes and communities. The waiver is operated through the DHS-DRS Home Services Program. It was initially approved October 1, 1983 and was renewed in fiscal year 2010 effective October 1, 2009 through September 30, 2014. The waiver served 20,499 individuals during federal fiscal year 2011.

Persons who are Elderly Waiver

Under the direction of the Department on Aging, the HCBS waiver program for the elderly supports individuals who are 60 years of age and older and who would qualify for the level of care provided in a NF. With the provision of special services, the waiver allows individuals to remain in their homes and communities, delaying placement into a nursing facility.

The waiver was initially approved October 1, 1983 and was renewed in fiscal year 2010 effective October 1, 2009 through September 30, 2014. The waiver served 34,977 seniors during federal fiscal year 2011.

Supportive Living Program Waiver

The Supportive Living Program has served as an alternative to Nursing Facility (NF) placement since 1999, providing an option for seniors 65 years of age or older and persons with physical disabilities between 22 and 64 years of age who require assistance with activities of daily living, but not the full medical model available through a nursing facility. The waiver was renewed for five years renewed beginning July 1, 2007.

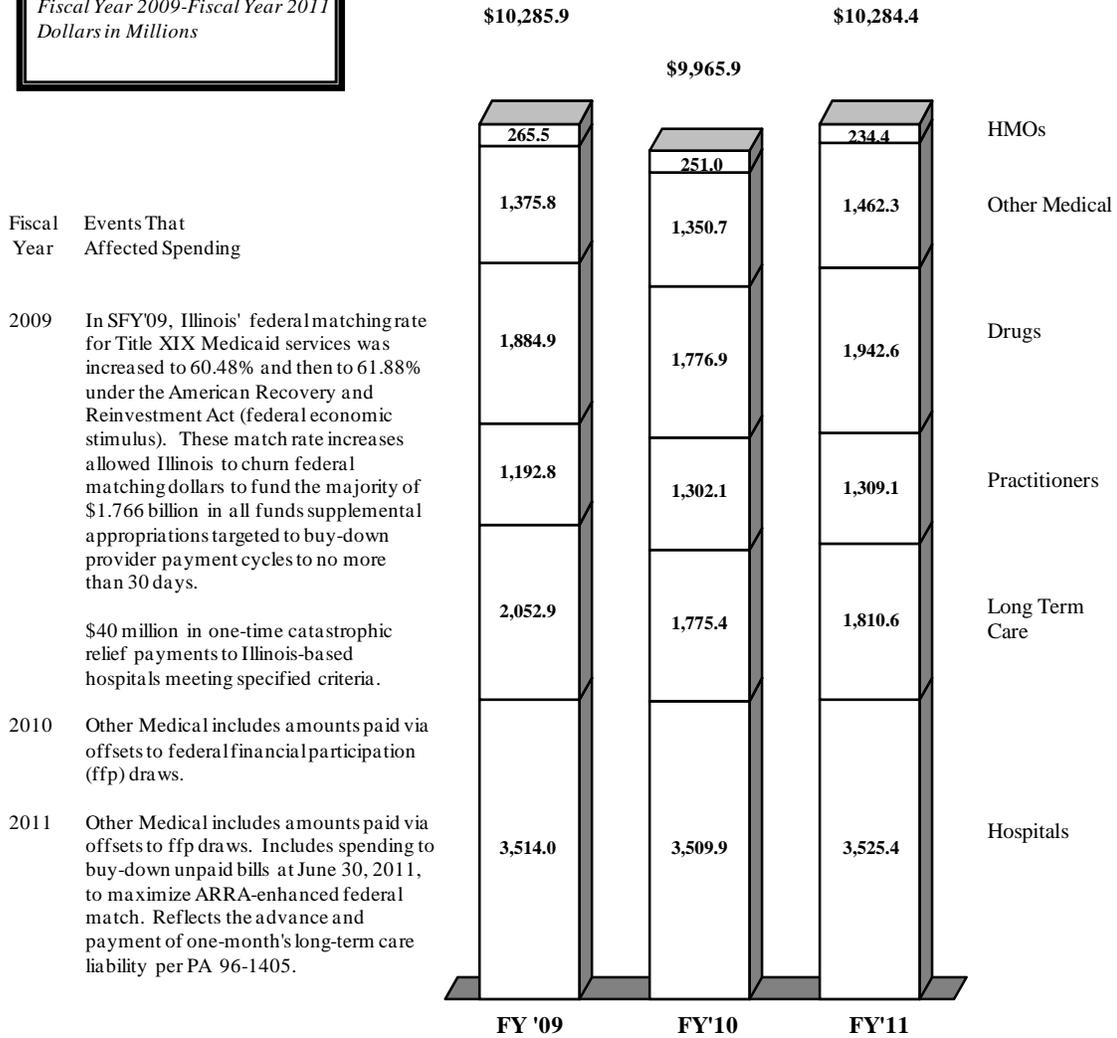
Participants reside in their own private apartment with kitchen or kitchenette, private bath, individual heating and cooling system and lockable entrance. Supportive Living Facilities (SLFs) are required to meet the scheduled and unscheduled needs of residents 24 hours a day. Services include routine health assessments, medication management, and assistance with personal care supplied by certified nurse aides, housekeeping, meals, laundry, activities and emergency call systems. Each resident is involved with the development of his/her individualized service plan that identifies the services to be provided based on the resident's needs and preferences.

This assisted living-style program offers services to help a nursing-home eligible individual prevent or delay admission to the more restrictive and costly nursing facility setting. The Medicaid reimbursement rate for providing Supportive Living Program services is based on 60 percent of the average nursing facility care rate. On average, 60 percent of SLF residents are Medicaid eligible.

During fiscal year 2011 over 8,600 Medicaid eligible residents participated in the program. At the end of fiscal year 2011, there were 128 SLFs, with a total of 9,967 apartments, in operation. This was a four percent increase in the number of SLFs and an eight percent increase in the number of apartments available from the previous year. There are 31 more facilities in various stages of development.

XXIV. GRAPHS

Graph I
Medical Programs Spending
Fiscal Year 2009-Fiscal Year 2011
Dollars in Millions

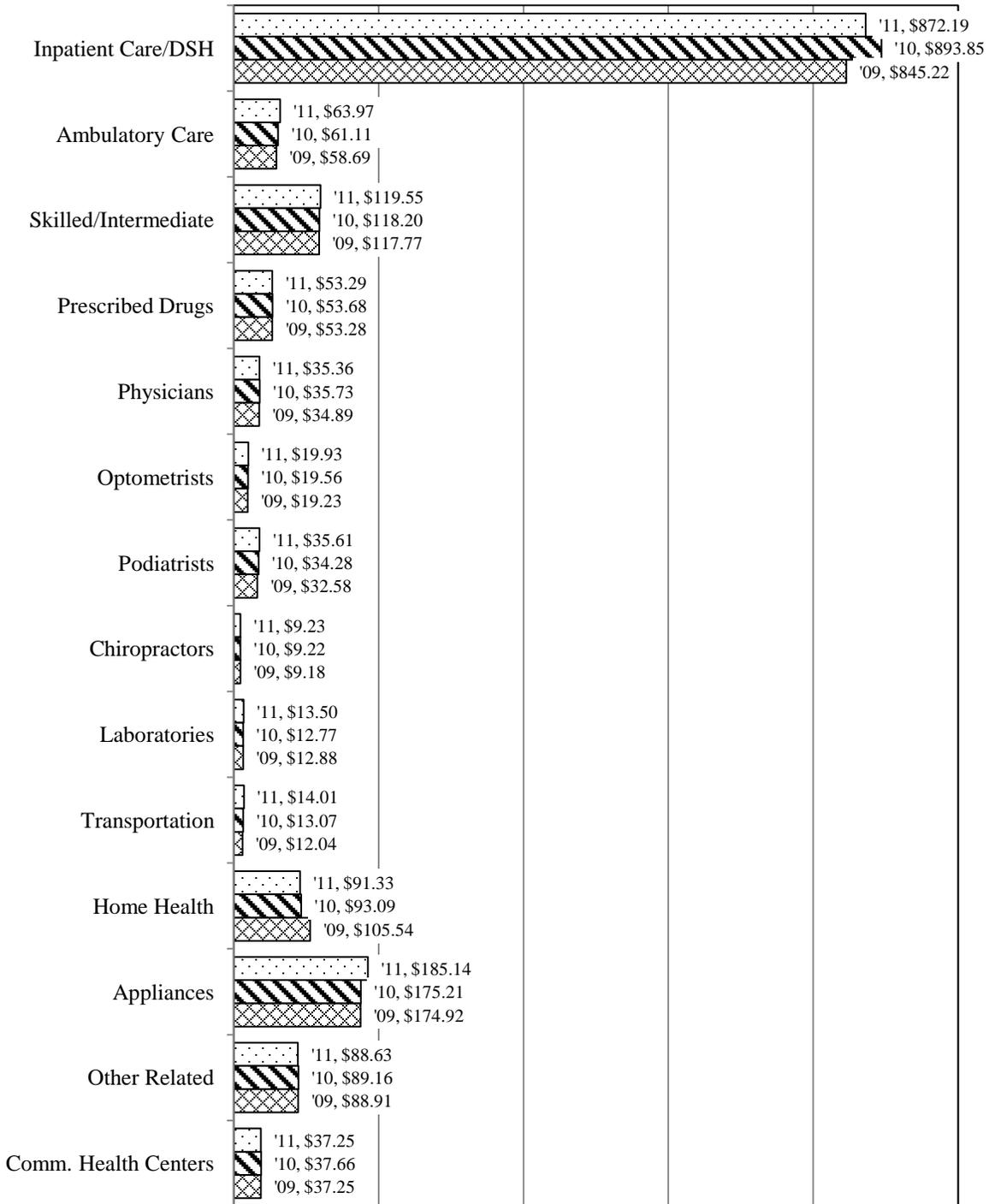


Note: Not included in total spending are expenditures from the (Cook) County Provider Trust, University of Illinois Hospital Services, Trauma Center, Non-entitlements, Hospital Provider (relating to the assessment), Medicaid Research and Development, Special Education Medicaid Match, Independent Academic Medical Center, Post- Tertiary Clinical Services and Juvenile Rehabilitation Services Funds.

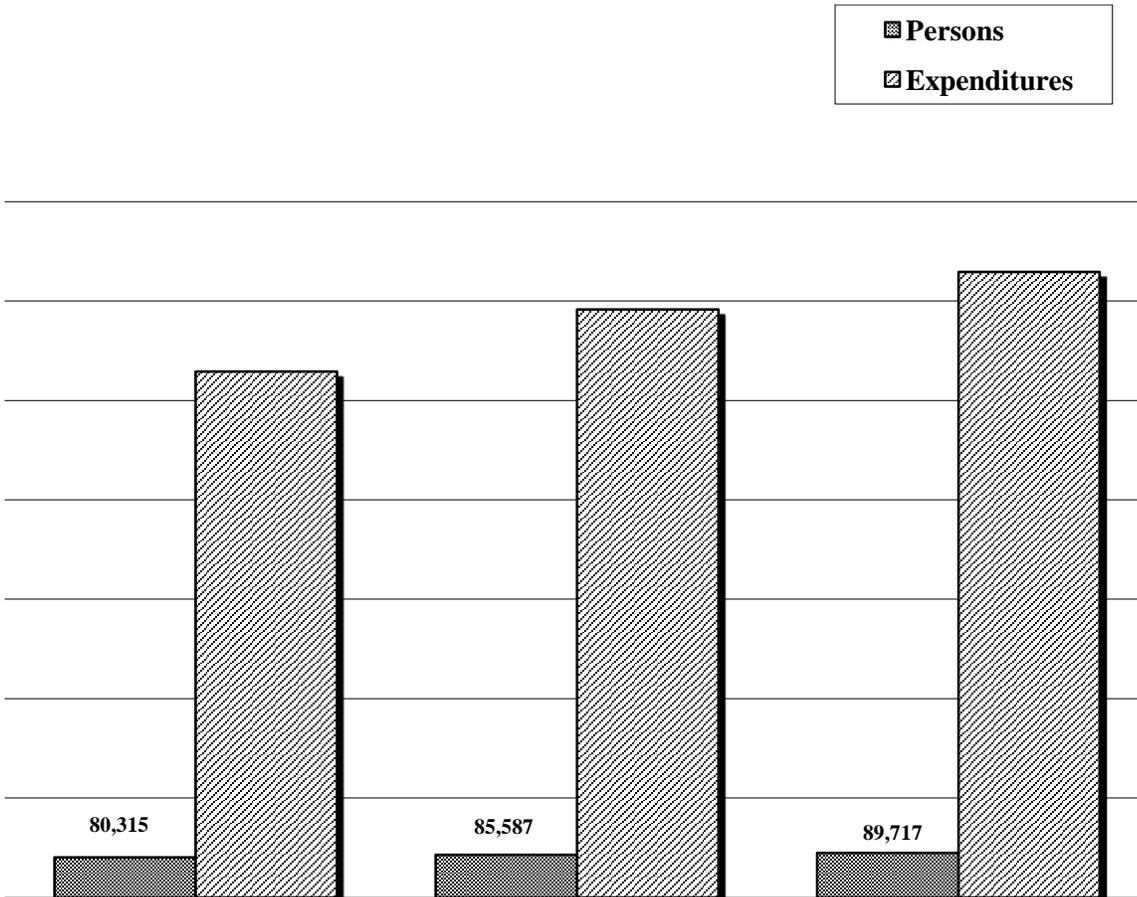
Graph Prepared By: Division of Finance
 Data Source: Division of Finance, Comptroller Spending Report FY'11, October 24, 2011.

Graph II
 Average Payment Per
 Unit of Service
 Fiscal Year 2009 - Fiscal Year 2011
 in Dollars

Bar Order
 □ '11
 ▨ '10
 ▩ '09



Graph III
 Medicaid Waiver
 Persons and Expenditures
 Federal Fiscal Year 2008–
 Federal Fiscal Year 2010



Note: All data was compiled from the Illinois Department of HealthCare and Family Services Medical Data Warehouse and all waiver data is based on a 10/1-9/30 fiscal year. Expenditures do not include costs for services for persons who are not Medicaid eligible. The prior year numbers have been revised to incorporate additional claims for the Federal Fiscal year than have been received by the Department.

Client data represents the combined unduplicated annual totals of Medicaid eligible persons served through HFS waivers managed by Aging, DHS and HFS.

Graph Prepared By: Bureau of Rate Development and Analysis
 Data Source: HFS Data Warehouse

XXV. TABLES

Table I
Licensed/Medicaid-Certified
Long Term Care Beds
Fiscal Year 2011 Actual

Level of Care	Medicaid	Licensed Beds 2
	Certified Beds 1	
Skilled Care	68,502	76,558
Intermediate Care	17,511	19,312
Intermediate Care for the Mentally Retarded (ICF/MR)	6,097	6,097
Skilled Pediatric Care	932	932
Total	93,042	102,899

1 Reflects those beds that participate in the Medical Assistance Program and are available to Medicaid residents.

2 Reflects beds licensed under the Nursing Home Care Act and hospital LTC units.

Table Prepared By: Bureau of Rate Development and Analysis

Data Source: Bureau of Long Term Care

Table II
Long Term Care Total Charges
and Liability on Claims Received
Fiscal Year 2009 - Fiscal Year 2011

	Long Term Care - Total			Percent Change FY'10 to FY'11
	FY'09	FY'10	FY'11	
Total Charges ¹ (\$ Millions)	\$2,277.70	\$2,320.51	\$2,507.80	8.07%
Total HFS Liability ¹ (\$ Millions)	\$1,768.54	\$1,792.26	\$1,911.30	6.64%
Total Patient Days	19.83	20.06	21.59	7.63%
Weighted Average Rate ²				
Per Diem	\$89.19	\$89.35	\$88.53	-0.92%
Average Payment (Charge) Per Diem	\$114.86	\$115.68	\$116.17	0.42%

1 Reflects date of service liability.

2 Excludes patient contributions and third-party payments.

Table Prepared By: Bureau of Rate Development and Analysis
 Data Source: Bureau of Rate Development and Analysis

Table III
Medical Assistance Program
Expenditures Against Appropriation
Fiscal Year 2009 -Fiscal Year 2011
Dollars in Thousands

	FY'09		FY'10		FY'11	
	Expenditures	Percent	Expenditures	Percent	Expenditures	Percent
Total	\$10,285,925.7	103.2%	\$9,965,922.5	96.9%	\$10,284,430.3	100.0%
Hospitals ¹	3,514,022.4	35.3%	3,509,887.3	34.1%	3,525,388.6	34.3%
Inpatient	N/A		N/A		N/A	
Ambulatory Care	N/A		N/A		N/A	
Long Term Care ²	2,052,879.6	20.6%	1,775,407.1	17.3%	1,810,618.9	17.6%
Practitioners	1,192,797.3	12.0%	1,302,094.1	12.7%	1,309,095.1	12.7%
Physicians	943,161.2	9.5%	982,963.0	9.6%	986,389.5	9.6%
Dentists	205,462.7	2.1%	267,582.1	2.6%	266,748.9	2.6%
Optometrists	36,112.8	0.4%	42,707.9	0.4%	46,889.4	0.5%
Podiatrists	6,629.1	0.1%	7,327.8	0.1%	7,549.4	0.1%
Chiropractors	1,431.5	0.0%	1,513.3	0.0%	1,517.9	0.0%
Drug	1,884,885.5	18.9%	1,776,864.6	17.3%	1,942,633.4	18.9%
Other Medical	1,367,294.8	13.7%	1,343,361.2	13.1%	1,456,351.0	14.2%
Laboratories	67,350.7	0.7%	56,943.0	0.6%	59,372.2	0.6%
Transportation	110,459.3	1.1%	94,284.9	0.9%	85,946.0	0.8%
SMIB/HIB/Expansion ³	303,430.1	3.0%	338,186.0	3.3%	390,931.5	3.8%
Home Health Care/DSCC	158,492.9	1.6%	155,622.1	1.5%	164,106.3	1.6%
Appliances	106,672.2	1.1%	90,468.8	0.9%	92,041.4	0.9%
Other Related ⁴	196,853.4	2.0%	200,124.6	1.9%	201,935.1	2.0%
Comm Health Centers	297,663.9	3.0%	291,401.8	2.8%	336,901.9	3.3%
Hospice Care	96,852.9	1.0%	84,314.4	0.8%	89,315.7	0.9%
Children's Mental Health Initiative	29,519.4	0.3%	32,015.6	0.3%	35,800.9	0.3%
HMOs	265,468.1	2.7%	250,979.9	2.4%	234,369.0	2.3%
Children's Rebate	8,578.0	0.1%	7,328.3	0.1%	5,974.3	0.1%

¹ Not included in total spending are expenditures from the (Cook) County Provider Trust, University of Illinois Hospital Services, Non-entitlements, Hospital Provider Fund (relating to the assessment), Trauma Center, Medicaid Research and Development, Special Education Medicaid Match, Independent Academic Medical Center, Post-Tertiary Clinical Services, and Juvenile Rehab Services Funds.

² Includes funds from the Provider Assessment Program, IMDs and SLFs.

³ Includes amounts paid via offsets to federal financial participation draws.

⁴ "Other Related" refers to medical equipment and supplies not paid through any other program, such as oxygen.

Table Prepared By: Division of Finance

Data Source: Division of Finance, Comptroller Spending Report FY'11, October 24, 2011.

Table IV
Medicaid Providers
By Type of Service
Fiscal Year 2007-
Fiscal Year 2011

Provider Type	FY'07	FY'08	FY'09	FY'10	FY'11	
Hospitals						
Cost Reporting	261	261	261	259	258	
Therapists ¹	4,046	4,069	4,047	4,044	4,467	
Clinics ²	593	651	670	712	714	
Long Term Care Facilities Total	1,128	1,143	1,158	1,156	1,161	
Nursing Facilities		746	745	743	738	734
ICF/MR		304	303	301	299	300
Supportive Living Facilities		78	95	114	119	127
Physicians	32,854	33,829	35,668	37,754	39,218	
Dentists ³	3,108	2,702	4,090	4,633	5,267	
Optometrists	619	690	780	820	933	
Podiatrists	530	557	578	593	605	
Chiropractors	572	544	554	539	546	
Pharmacies	2,718	2,723	2,779	2,796	2,849	
Laboratories/Portable X-rays	349	380	405	446	474	
Transportation	1,341	1,467	1,613	1,592	1,719	
Home Health Agencies	311	329	333	335	359	
Managed Care Organizations ⁴	2	2	3	3	3	
Hospice	109	110	108	107	108	
Durable Medical Equipment	1,365	1,397	1,416	1,391	1,478	
Community Health Agency	7	7	7	7	7	
Other Providers ⁵	3,240	3,752	4,626	4,896	5,780	
Total Providers	53,153	54,613	59,096	62,083	65,946	

¹ Included in "Therapists" are Occupational, Physical and Speech Therapists and Audiologists.

² "Clinics" includes Ambulatory Surgical Centers, Encounter Rate Clinics, FQHCs, Rural Health Clinics, Healthy Kids and hospital based Healthy Moms/Healthy Kids Clinics.

³ Reflects the number of dental sites that were available through the Department's contractor.

⁴ Includes MCCNs.

⁵ "Other Providers" consist of DORS schools, Early Intervention, Advance Practice Nurses and Optical Companies.

Table V. Illinois Medical Assistance Mandatory/Optional Services

FEDERALLY REQUIRED MEDICAL ASSISTANCE SERVICES PROVIDED IN FY 2011

Ambulatory services provided by rural health clinics and federally qualified health centers
 Ambulatory services to presumptively eligible pregnant women
 Early and periodic screening, diagnosis and treatment for individuals under 21 yrs of age
 Emergency services to non-citizens
 Family planning services and supplies
 Home health:
 –Home health aide
 –Medical supplies, equipment and appliances
 –Nursing services
 –Physical, occupational and speech therapies; audiology services

Inpatient hospital services (other than those provided in an institution for mental diseases)
 Medical and surgical services performed by a dentist
 Nurse practitioner (pediatric and family only)
 Nurse-midwife services
 Nursing facility and home health services for individuals 21 years of age and older
 Outpatient hospital services
 Other laboratory and x-ray services
 Physician services
 Pregnancy-related services and services for other conditions that might complicate pregnancy
 Transportation

OPTIONAL SERVICES PROVIDED IN FY 2011

Care of individuals 65 years of age or older in institutions for mental diseases (IMD):
 – Inpatient hospital services, including State-operated facilities
 – Nursing facility services
 Case management services
 Chiropractic services
 Clinic services (Medicaid clinic option)
 Dental services:
 – Dentures
 – Emergency services
 Diagnostic services, including durable medical equipment and supplies
 Emergency hospital services
 Eyeglasses
 Home- and community-based services, through federal waivers:
 – Adults with developmental disabilities (18 years of age or older)
 – Children that are medically fragile and technology dependent (under 21 years of age)
 – Individuals who are elderly (60 years of age or older)
 – Individuals with brain injuries
 – Individuals with disabilities
 – Individuals with HIV or AIDS
 – Children with Developmental Disabilities Residential Waiver (3 through 21 years)
 – Children with Developmental Disabilities Home-Based Support Waiver (3 through 21 years)
 – Supportive living facilities (22 through 64 years of age with disabilities; 65 years of age or older)

Hospice care services
 Inpatient psychiatric services (IMD) for individuals under 21 years of age, including State-operated facilities
 Intermediate care facility services for the mentally retarded (ICF/MR), including State-operated facilities
 Nurse anesthesia services
 Nursing facility services for individuals under 21 years of age
 Occupational therapy services
 Optometric services
 Other practitioner services
 Physical therapy services
 Podiatric services
 Prescribed drugs
 Preventive services, including durable medical equipment and supplies
 Prosthetic devices, including durable medical equipment and supplies
 Rehabilitative services (Medicaid rehabilitation option)
 Religious non-medical health care institution services
 Services provided through a health maintenance organization or a prepaid health plan
 Screening services
 Special tuberculosis-related services
 Speech, hearing and language therapy services
 Transplantation services

**Table VI
Claims Receipts History
Fiscal Year 2009 to 2011**

	FY09	FY10	FY11	% Change FY09-FY11	% of Total Claims FY11
Total Claims Received	86,144,995	88,825,209	90,876,852	5.5%	
Pharmacy	34,740,116	38,719,681	41,551,228	19.6%	45.7%
Physicians	29,704,693	29,894,559	30,210,594	1.7%	33.2%
Medicare	9,781,551	8,171,732	7,241,361	-26.0%	8.0%
Hospitals	4,684,859	4,933,405	5,078,678	8.4%	5.6%
Transportation Services	2,317,418	2,187,190	1,910,150	-17.6%	2.1%
Laboratory	2,190,736	1,970,450	1,889,279	-13.8%	2.1%
Medical Equip/Supply	1,758,352	1,998,970	2,063,625	17.4%	2.3%
Long Term Care	822,482	822,165	817,112	-0.7%	0.9%
Health Agency	101,873	90,304	96,147	-5.6%	0.1%
All Other Categories	42,915	36,753	18,678	-56.5%	0.0%

**Table VII
Home and Community Based-Services Waivers**

FY2011 Capacity, Operating Agency, Waiver Begin/End Dates, Target Populations, Base Services and Waiver Changes Since Last Renewal

Medically Fragile/Technology Dependent Children Operating Agency: Division of Specialized Care for Children Target Population: Medically Fragile, Technology Dependent children under age 21			
Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 07/01/85 Renewal 09/01/07-08/30/12 FFY 2011 Capacity 700 # Served 606 Expenditures \$2,374,745	<ul style="list-style-type: none"> • Respite care • Environmental modifications • Specialized medical equipment and supplies • Medically supervised day care • Placement maintenance counseling • Nurse and family training 	None	<ul style="list-style-type: none"> • Implemented a new level of care tool to determine waiver eligibility effective 03/01/09. • Changed institutional cost comparison population from hospital and skilled pediatric nursing facility to hospital and nursing facility. Other: On 3/25/11 received draft report with recommendations of additional performance measures and implementation of monitoring using a statistically valid sample. State response due 6/23/11.

Elderly Operating Agency: Department on Aging Target Population: Over 60.			
Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 10/01/83 Renewal 10/01/09-09/30/14 FFY 2011 Capacity 33,058 # Served 34,977 (exceeded capacity) Expenditures \$268,176,957	<ul style="list-style-type: none"> • Homemaker • Adult day services • Personal Emergency Response System 	None	Renewal approved 09/14/09 with an effective date of 10/01/09. There were no major changes.

Adults with Developmental Disabilities

Operating Agency: Department of Human Services, Division of Developmental Disabilities
Target Population: Developmental Disabilities, age 18 and older

Begin/End Date	Base Services	• Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 07/01/83 Renewal 07/01/07-06/30/12 FFY 2011 Capacity 17,600 # Served 17,401 Expenditures \$523,285,868	<ul style="list-style-type: none"> • Case Management • Adult day care • Residential habilitation • Home-based services • Day habilitation • Supported employment • Environmental modifications • Specialized medical equipment and supplies • Physical , occupational, and speech therapies • Behavioral services • Personal support • Nursing • Transportation • Crisis Services • Assistive Technology • Training and counseling for unpaid caregivers 	<ul style="list-style-type: none"> • Crisis Services • Assistive Technology • Training for Unpaid Caregivers • Counseling for Unpaid Caregivers 	<p>At Renewal:</p> <ul style="list-style-type: none"> • Added fiscal management entity for self-directed services • Removed out-of-home respite <p>Amendment approved 09/09/10 requesting an effective date of 07/01/09 to increase the capacity from 15,225 to 15,920.</p> <p>Other: On 6/7/11, HFS received the final federal CMS Management Review report. DDD and HFS have begun implementing the new performance measures that were developed as a result of the CMS review.</p>

Children with Developmental Disabilities – Residential

Operating Agency: Department of Human Services, Division of Developmental Disabilities
Target Population: Developmental Disabilities, ages 3-21

Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 07/01/10 End Date 06/30/15 FFY 2011 Capacity 258 # Served 273 (exceeded capacity) Expenditures \$18,879,267	<ul style="list-style-type: none"> • Adaptive equipment • Assistive technology • Behavioral services • Residential habilitation 	N/A	<p>On 09/09/10 amendment approved requesting an increase in the capacity from 201 to 258. The effective date is 07/01/09.</p> <p>Renewal: On 10/28/10 federal CMS approved the waiver renewal effective 07/01/10-06/30/15.</p>

Children with Developmental Disabilities – Support

Operating Agency: Department of Human Services, Division of Developmental Disabilities
Target Population: Developmental Disabilities, ages 3-21

Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
<p>Begin Date 07/01/10</p> <p>End Date 06/30/15</p> <p>FFY 2011</p> <p>Capacity 1,400</p> <p># Served 1,380</p> <p>Expenditures \$15,876,093</p>	<ul style="list-style-type: none"> • Home and vehicle accessibility modifications • Adaptive equipment • Assistive technology • Behavioral services • Service facilitation • Personal support • Caregiver training and counseling 	<ul style="list-style-type: none"> • Temporary Assistance 	<p>On 09/09/10 amendment approved requesting an increase in the capacity from 1,100 to 1,300. The effective date is 07/01/09.</p> <p>Renewal: On 09/28/10 federal CMS approved the waiver renewal effective 07/01/10-06/30/15.</p>

Persons with Brain Injuries

Operating Agency: Department of Human Services, Division of Rehabilitation Services
Target Population: Brain Injury, all ages

Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
<p>Begin Date 07/01/99</p> <p>Renewal 07/01/07 06/30/12</p> <p>FFY 2011</p> <p>Capacity 7,889</p> <p># Served 4,771</p> <p>Expenditures \$80,561,951</p>	<ul style="list-style-type: none"> • Homemaker • Home health aide • Personal care • Adult day care • Habilitation • Supported employment • Nursing • Prevocational services • Environmental accessibility • Specialized medical equipment and supplies, • Personal Emergency Response System • Physical, occupational, and speech therapies • Behavioral/cognitive services • Home delivered meals • Respite 	None	<p>On 6/29/10, the federal Centers for Medicare and Medicaid Services (CMS) announced a Quality Review of this program. An evidentiary report is due to CMS by 9/28/10.</p> <p>Other: On 09/27/10 HFS submitted evidentiary report to federal CMS, demonstrating compliance with six federal assurances.</p> <p>On 12/22/10, HFS received draft report from federal CMS. Response was due by 03/21/11. It was submitted on 3/3/11.</p> <p>On 6/22/11 HFS and DRS are meeting with the CMS Technical Assistance Team to discuss new performance measures for the waiver renewal.</p>

Persons Diagnosed with HIV/AIDS

Operating Agency: Department of Human Services, Division of Rehabilitation Services
Target Population: HIV/AIDS, all ages

Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 10/01/90 Renewal 10/01/08-09/30/13 FFY2011 Capacity 1,529 # Served 1,406 Expenditures \$16,874,157	<ul style="list-style-type: none"> • Homemaker • Home health aide services • Personal care, • Nursing • Environmental access • Personal Emergency Response System • Home delivered meals • Adult day care • Physical, occupational, and speech therapies • Special equipment and supplies • Respite 	None	Renewal approved 09/02/08 with an effective date of 10/01/08. Major changes include: <ul style="list-style-type: none"> • Level of care comparison changed from hospital to nursing facility • Removal of transportation to work as a service

Persons with Disabilities

Operating Agency: Department of Human Services, Division of Rehabilitation Services
Target Population: Disabilities (0-59). Over 60, if entered program prior to 60th birthday

Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 10/01/83 Renewal 07/01/09-06/30/14 FFY 2011 Capacity 31,593 # Served 20,499 Expenditures \$290,898,283	<ul style="list-style-type: none"> • Homemaker • Home health aide • Personal care • Respite • Adult day care • Environmental accessibility • Nursing • Personal Emergency Response System • Home delivered meals • Physical, occupational, and speech therapies • Special Equipment and Supplies • Respite 	None	Renewal approved 09/25/09 with an effective date of 10/01/09. There were no major changes.

Supportive Living

Operating Agency: Department of Healthcare and Family Services, Bureau of Long Term Care
Target Population: Aged, 65 and over; Disabilities, age 22-64

Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 07/01/99 Renewal 07/01/07-06/30/12 FFY 2011 Capacity 10,900 # Served 8,127 Expenditures \$125,806,979	<ul style="list-style-type: none"> • Nursing • Personal care • Medication oversight and assistance with self-administration • Laundry • Housekeeping • Maintenance • Social/recreational programming • Ancillary (transportation to group/community activities, shopping, arranging outside services) • 24-hour response/security staff • Health promotion and exercise programming • Emergency call system 	None	None since renewal Other: On 06/02/11, HFS received the final federal CMS Management Review report. On 6/22/11 HFS is meeting with the CMS Technical Assistance Team to discuss new performance measures for the waiver renewal.

**Table VIII
Client Hotline Numbers**

All Kids (All Kids Hotline)	1-866-255-5437
Client (Illinois Health Benefits & All Kids Hotline)	1-800-226-0768
Drug Prior Approval/Refill-Too-Soon	1-800-252-8942
Drug Prior Approval/Refill-Too-Soon AVRS	1-800-642-7588
4 Our Kids (Illinois Health Benefits & All Kids Hotline)	1-866-468-7543
Kids Now (Federal toll-free number that connects directly to the Medicaid or Children's Health Insurance Program staff in the state from which the call is made. In Illinois it connects to the Illinois Health Benefits & All Kids Hotline)	1-877-543-7669
Client Eligibility- AVRS	1-800-842-1461
TTY (for hearing impaired)	1-877-204-1012

Back Cover

This report was prepared to meet the obligation of five statutory requirements:

- 1.) 305 ILCS 5/5-5 requiring the Department to report annually no later than the second Friday in April, concerning:
 - “actual statistics and trends in utilization of medical service by Public Aid recipients,
 - actual statistics and trends in the provision of the various medical services by medical vendors,
 - current rate structures and the proposed changes in those rate structures for the various medical vendors, and
 - efforts at utilization review and control by the Department of Public Aid.”
- 2.) 305 ILCS 5/5.8 requiring the Department to report annually to the General Assembly, no later than the first Monday in April, in regard to:
 - “the rate structure used by the Department to reimburse nursing facilities,
 - changes to the rate structure for reimbursing nursing facilities,
 - the administrative and program costs of reimbursing nursing facilities,
 - the availability of beds in nursing facilities for Public Aid recipients, and
 - the number of closings of nursing facilities and the reasons for those closings.”
- 3.) 20 ILCS 2407/55 requiring the Department to report annually on Money Follows the Person, no later than April 1 of each year in conjunction with the annual report, concerning:
 - “a description of any interagency agreements, fiscal payment mechanisms or methodologies developed under this Act that effectively support choice,
 - information concerning the dollar amounts of State Medicaid long-term care expenditures and the percentage of such expenditures that were for institutional long-term care services or were for community-based long-term care services, and
 - documentation that the Departments have met the requirements under Section 54(a) to assure the health and welfare of eligible individuals receiving home and community-based long-term care services .”
- 4) 305 ILCS 5/5-29 requiring the Department to submit an analysis on the children’s programs and waivers as part of the Department’s annual reports due to the General Assembly in 2011 and 2012. The analysis should determine:
 - parental cost sharing opportunities;
 - how the opportunities may impact children currently in the programs, waivers and on waiting lists;
 - other factors which may increase efficiencies and decrease State costs;
 - how services under these programs and waivers may be provided by the use of a combination of skilled, unskilled, and uncompensated care.
- 5) 215 ILCS 106/23 requiring the Department report to the General Assembly in a separate part of its annual Medical Assistance Program report, beginning April, 2012 until April 2016, on the progress and implementation of the care coordination program initiatives.

For additional copies contact the Department of Healthcare and Family Services’ Bureau of Long Term Care, 3rd Floor, Prescott E. Bloom building, 201 South Grand Avenue East, Springfield, Illinois 62763.

WCS 8229X (R-X-12)

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