ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

Fiscal Years 2010, 2011 and 2012

Submitted April 1, 2013

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 2012. This document consolidates the reporting requirements under Sections 5-5 and 5-5.8 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. Information on HFS' Medical Assistance Programs is provided for the most recently completed fiscal year 2012 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 2012 in compliance with reporting requirements.

In addition, this report contains updates on the Department's efforts in implementing Illinois' Medicaid reform legislation *[P. A. 96-1501* and *P. A. 97-689]* and the federal *Affordable Care Act [P.L. 111-148]*. Over the past year HFS has made steady progress in developing a healthcare system that is more patient-centered, with a focus on improved health outcomes and evidence-based treatments, enhanced patient access and patient safety. A few of the reform milestones the Department achieved include:

- In May of 2012, received 20 proposals in response to the Care Coordination Innovations Project solicitation. Upon evaluation, six proposals were selected (5 CCEs and 1 MCCN) for initial awards based on their demonstrated ability to offer an innovative holistic approach to delivering coordinated care.
- In May of 2012, released the Request for Proposal for the Medicare-Medicaid Alignment Initiative. Upon evaluation, eight managed care organizations were chosen to provide the full range of Medicare and Medicaid benefits with a robust care coordination component, a comprehensive provider network and utilization of community-based services to maintain independence in the community.
- Illinois received federal approval of its State Medicaid Health Information Plan and in March of 2012, the Department disbursed the first payments under the Electronic Health Record (EHR) Provider Incentive Payment (PIP) program which pays a 100 percent federally funded incentive payment to eligible Medicaid providers for the adoption, implementation and meaningful use of certified EHR systems.
- Under the CHIPRA Quality Demonstration Grant, HFS partnered with the Illinois Chapter of American Academy of Pediatrics (ICAAP) to recruit medical practices to participate in the National Committee on Quality Assurance Patient –Centered Medical Home self-assessment survey tool to identify the strengths and needs of medical practices serving as medical homes. The baseline data acquired from the survey were used by to develop training specific to the identified needs.

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 Programs

CONTENTS

I. OVERVIEW ..... Page 1

II. THE FUTURE OF MEDICAID – CARE COORDINATION ..... Page 2

III. OTHER 2012 INITIATIVES ..... Page 4

A. Reimbursement Redesign
B. SMART Act Implementation
C. Money Follows the Person - Long Term Care Rebalancing Annual Report

IV. INFORMATION SYSTEM IMPROVEMENTS ..... Page 8

V. LONG TERM CARE ..... Page 11

VI. HOME AND COMMUNITY-BASED SERVICES WAIVERS ..... Page 12

VII. MATERNAL AND CHILD HEALTH ..... Page 14

VIII. DENTAL PROGRAM ..... Page 23

IX. CARE MANAGEMENT ..... Page 24

X. MEDICAID PROVIDER ASSESSMENT PROGRAM ..... Page 29

XI. PROVIDER REIMBURSEMENT ..... Page 30

XII. REIMBURSING HOSPITALS ..... Page 30

XIII. REIMBURSING LONG TERM CARE FACILITIES ..... Page 36

XIV. REIMBURSING MANAGED CARE ORGANIZATIONS ..... Page 36

XV. REIMBURSING PHARMACY SERVICES ..... Page 38

XVI. REIMBURSING SCHOOL BASED SERVICES ..... Page 40

XVII. REIMBURSING OTHER PROVIDERS ..... Page 40

XVIII. QUALITY ASSURANCE, UTILIZATION AND CONTROL ..... Page 42

XIX. ACRONYMS ..... Page 50

XX. APPENDICES ..... Page 52

A. Eligibility Groups and Program Descriptions
B. Overview and current activity of HCBS Waiver Programs
C. Final Budget Actions Worksheet on SMART Act

XXI. GRAPHS ..... Page 67

I. Medical Program Spending
II. Average Payment Per Unit of Service
III. Medicaid Waiver Persons and Expenditures

XXII. TABLES ..... Page 70

I. Licensed Medicaid-Certified LTC Beds-FY2011 Actual
II. LTC Total Charges and Liability on Claims Received
III. Medical Assistance Program Expenditures Against Appropriation
IV. Medicaid Providers
V. Medical Assistance Mandatory/Optional Services
VI. Claims Receipts History
VII. Home and Community Based Services Waivers
VIII. Hotlines for Health Benefits, All Kids and Drug Prior Approval/Refill to Soon

BACK COVER – List of Statutory Requirements

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 2012, Medicaid, and the medical programs associated with it, provided comprehensive health care coverage to approximately 2.8 million Illinoisans and partial benefits to 269,000 individuals.

On average, each month the Department's programs cover approximately 3.1 million enrollees, including 1.7 million children, 178,000 seniors, 266,000 persons with disabilities, 647,000 non-disabled, non-senior adults and 269,000 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	**FY2010**	**FY2011**	**FY2012**
Children	1,630,495	1,677,575	1,697,175
Disabled Adults	253,973	260,228	266,664
Other Adults	608,659	636,531	647,451
Seniors	161,356	168,943	178,098
All Comprehensive	2,654,483	2,743,277	2,789,388
All Partial Benefits	294,039	309,387	269,336
Grand Total All Enrollees	**2,948,522**	**3,052,664**	**3,058,724**

The Department administers the Medical Assistance Programs 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, the Department 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 (UIC), and hundreds of local school districts.

The Medical Assistance Programs are funded jointly by State and federal governments and, in certain instances, local governments. During fiscal year 2012, the Department spent approximately $12.4 billion (all funds), of which $9.13 billion was GRF/GRF like funds, on health benefits provided to enrollees. These individuals were served by 73,580 providers of medical services, including 43,151 physicians, 2,883 pharmacies, 454 home health agencies, 260 hospitals and 732 nursing facilities. Further detail on enrollment by provider type can be found in Table IV.

Illinois' Medical Assistance Programs covers 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. Descriptions of the major eligibility groups and Medical Assistance Programs can be found in Appendix A of this report.

II. THE FUTURE OF MEDICAID – CARE COORDINATION

Care Coordination, aligned with the Illinois Medicaid reform law (*Public Acts 096-1501* and *97-689)* and the federal Affordable Care Act *(Public Law 111-148)*, is the centerpiece of the Department's Medicaid reform efforts. HFS recognizes that the transition from a fee-for-service system to a more integrated healthcare delivery system will require major changes for the provider community and clients. Risk and performance must be tied to reimbursement in order to continue to transform the Medicaid healthcare delivery system to one with a focus on improved health outcomes. To accomplish this, HFS presents the following timeline for the development of its Care Coordination initiatives in the present year:

February, 2013

- ◊ Integrated Care Program: Aetna Better Health and IlliniCare Health Plan (Centene) added "Service Package II" Long Term Supports and Services for approximately 36,000 Seniors and Persons with Disabilities (SPDs) who reside in suburban Cook and collar counties.

April, 2013

- ◊ Commence enrollment in care coordination for approximately 5,000 SPD adults in Rockford by three managed care organizations, including one managed care community network (MCCN).

July, 2013

- ◊ Begin care coordination for approximately 21,000 SPD adults in Central Illinois, Quad Cities and Metro East Illinois by a variety of managed care organizations.
- ◊ Begin rolling out care coordination for adults with complex health needs served by provider-organized Care Coordination Entities (CCEs), initially five CCEs.
- ◊ Expand care coordination to include over 5,000 children with complex health needs by CCEs in various areas of the State.

Summer 2013

- ◊ Select projects from solicitation to provide care coordination for children with complex health needs.

October, 2013

- ◊ Medicare-Medicaid Alignment Initiative: Integrated care models to begin serving approximately 136,000 dual-eligible (Medicare/Medicaid) clients under dual-capitation in Central Illinois and the Chicago region.

A. Integrated Care Program

The Integrated Care Program (ICP), the State's first mandatory integrated healthcare program, was implemented in May of 2011. The ICP is a program for seniors and persons with disabilities who are eligible for Medicaid, but not eligible for Medicare. As of September 2012, approximately 36,090 clients had been enrolled in the ICP.

The program operates in the pilot areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. To achieve improvements in health, the ICP coordinates care between local primary care physicians, specialists, hospitals, nursing homes and other providers so that all care is organized around the needs of the client. The ICP will be phased in as three service packages, and it began with the initial rollout of Service Package I for acute health. Service Package II covers Long-Term Services and Supports and became effective February 1, 2013. Additional information on the ICP can be found in Section IX, Care Management, of this report and on the Integrated Care Program webpage on the Department's Web site.

B. Care Coordination Innovations Project

The Medicaid reform law requires HFS to move at least 50 percent of recipients eligible for comprehensive medical benefits in all programs administered by the Department 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's goal, HFS, in collaboration with other State Agencies and community partners, developed the Care Coordination "Innovations Project." The Innovations Project is designed to test community interest and capacity to provide alternatives to MCO models of delivering care, align with Affordable Care Act initiatives, incorporate feedback from stakeholders and build on interagency collaborations.

In early 2012, the Department released a solicitation seeking qualified and financially sound CCEs and MCCNs to enter into contracts to coordinate care for SPDs with a particular emphasis on managing transitions between levels of care and coordination between physical and mental health. Priority populations include SPDs (including those in long-term care, those with serious mental illness, and waiver populations) and individuals with Medicare (including clients with both Medicare and Medicaid, and long term care). The solicitation was developed by the Office of the Governor, DHS Divisions of Mental Health, Substance Abuse, Developmental Disabilities, and Rehabilitation Services, the Department on Aging and HFS.

The solicitation fulfilled a goal to allow providers to design and offer care coordination models other than traditional Health Maintenance Organizations (HMOs). The Department was 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 would have fulfilled the statutory mandate through traditional HMOs. Proposals were received from twenty offerors in May 2012. Upon evaluation, the Department selected six proposals for initial awards to five CCEs and one MCCN based on their demonstrated ability to offer an innovative holistic approach to delivering coordinated care. As recommended by the stakeholder group established under the Medicaid reform law [*P.A. 96-1501*], a second solicitation to serve Children with Complex Medical Needs was released in December 2012. For additional information on this solicitation refer to topic D., Care Coordination for Children with Complex Needs, below.

C. Medicare-Medicaid Alignment Initiative

The Medicare-Medicaid Alignment Initiative (MMAI) will integrate services covered in Medicare and Medicaid under one managed care program and combine 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 eligible for both Medicare and Medicaid (known as "dual eligibles") to navigate. HFS and the federal Centers for Medicare and Medicaid Services (CMS) will contract with Managed Care Organizations (MCOs) 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.

HFS released the MMAI Request for Proposal in the spring of 2012. Twelve proposals were received by nine companies and HFS selected eight health plans to serve clients in the MMAI and other initiatives in two regions of the state. HFS announced the following six managed care organizations to serve MMAI clients in the Greater Chicago area, consisting of Cook, Lake, Kane, DuPage, Will and Kankakee counties: Aetna Better Health, IlliniCare Health Plan (Centene), Meridian Health Plan of Illinois, HealthSpring of Tennessee d/b/a HealthSpring of Illinois, Humana Health Plan, and Health Care Service Corporation d/b/a Blue Cross/Blue Shield of Illinois. The State also announced the selection of Molina Healthcare of Illinois and Health Alliance Medical Plans to serve clients in Central Illinois, which includes Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell and Vermilion counties. The health plans were selected based on their demonstrated ability to offer a holistic approach to delivering coordinated care for dual

eligible clients. The initial awards are anticipated to extend for a maximum of three years. On February 22, 2013, the Department received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the MMAI, by reaching agreement and signing a Memorandum of Understanding that details the policies of the MMAI demonstration. Enrollment in the MMAI program is expected to start in the fall of 2013.

D. Care Coordination for Children with Complex Needs

In December 2012, HFS released its Solicitation for Care Coordination Entities (CCEs) for Children with Complex Medical Needs (CCMN), a component of the Care Coordination Innovations Project. Proposals to the Solicitation are due April 1, 2013. The State is seeking the services of qualified, experienced and financially sound CCEs to serve children with complex medical needs as part of a redesigned health care delivery system that is more patient-centered with a focus on improved health outcomes, enhanced patient access, and patient safety. A CCE is a collaboration of providers and community agencies, governed by a lead entity, which receives a care coordination payment with a portion of the payment at risk for meeting quality outcome targets, in order to provide care coordination services for its enrollees. The CCMN collaboration must include, at a minimum, participation from Primary Care Providers (PCPs), a hospital, pediatric specialist providers, behavioral health providers, and dental providers. The State is looking for the most comprehensive models that take a holistic approach to individuals served and attempts to coordinate services for all of their needs. CCMN's will coordinate care across the spectrum of the healthcare system with a particular emphasis on managing transitions between levels of care and coordination between physical and behavioral health. They will 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.

E. Medicaid Emergency Psychiatric Demonstration

In fiscal year 2012, Illinois was chosen to participate in the Medicaid Emergency Psychiatric Demonstration (MEPD), authorized under section 2707 of the *Affordable Care Act*. The Demonstration allows Medicaid claiming for persons served in a hospital Institution for Mental Diseases (IMD) in order to reduce psychiatric boarding, a term that describes when a person with a mental illness stays longer than medically necessary in an emergency department (ED). HFS, in cooperation with DHS-DMH, chose to take advantage of this opportunity to test an altered service delivery and financial model for funding community and hospital services, specifically structured to reduce inpatient psychiatric recidivism among adult clients. The Illinois MEPD project goals include: 1. Reduce lengthy emergency department stays for people with mental illness in participating demonstration area; 2. Decrease re-admission for psychiatric needs of persons served; 3. Increase the overall quality of service delivery of persons served; and 4. Enhance coordination of services with Community Mental Health Center (CMHC) providers. The MEPD project will operate until June 30, 2015, or until federal funding for the project is exhausted. It is anticipated that the MEPD project will include a maximum of 600 unique consumers across the three years of operation.

III. OTHER 2012 INITIATIVES

A. Reimbursement Redesign

To achieve better healthcare outcomes, HFS' reimbursement structures for many providers (especially hospitals and nursing facilities) are being redesigned. To accomplish this, HFS has embarked on a collaborative approach with the broader provider community.

In March 2011, HFS initiated a dialogue with both hospital and long-term care providers that will modernize the reimbursement systems, reflect patient-centered care and promote quality outcomes. This will result in more efficient use of State resources by focusing reimbursement based on the complexity of healthcare needs of Medicaid patients and those currently underfunded areas critical to achieve better management of care.

Hospitals

In July of 2011, the Department established a hospital Technical Advisory Group (TAG) consisting of CEOs, CFOs and consultants representing numerous hospitals and hospital systems from across the state to assist in redesigning its hospital reimbursement system. To date, there have been twelve 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 FAQ documents providing the Department's response to individual TAG member questions. This information can be viewed on the Department's Hospital Rate Reform Initiative Web page.

In the summer of 2012, the General Assembly passed *Public Act 097-0689*, [Save Medicaid Access and Resources Together (SMART) Act], mandating rate reform and putting forth time lines and structural guidelines for HFS' hospital reimbursement reform initiative. Per the act, the new hospital inpatient system may be implemented as early as July 1, 2013 and the new outpatient system may be implemented as early as January 1, 2014. The Department expects to finalize this process and have rules adopted in JCAR by December 31, 2013.

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

The SMART Act also outlines the direction of a new reimbursement system for nursing facilities, and extends the effective date for implementation (originally July 1, 2012) of the new system. For services provided on or after January 1, 2014, a reimbursement system that is based on Resource Utilization Groups (RUGs) must be in place for nursing facility services. The methodology will be resident-driven, facility-specific, and cost-based.

The Department continues to engage in dialogue with representatives of the nursing home industry on the development of this RUGs-based reimbursement methodology, which began during the summer of 2010.

B. SMART Act Implementation

The *Save Medicaid Access and Resources Together Act* (SMART Act) was developed after a review of the entire Medicaid program by the bipartisan Legislative Medicaid Advisory Committee. The Illinois Medicaid system was on the brink of collapse, with a $2.7 billion funding shortfall in the fiscal year 2013 Medicaid budget. Without solving the Medicaid crisis, the program would have continued to eat into the rest of the budget, limiting the ability to fund critical state priorities, including education, public safety and the capital construction program. The final Medicaid legislative package included 4 bills:

- SB 2840: *Save Medicaid Access and Resources Together Act* (SMART Act) includes $1.6 billion in 62 spending reductions, utilization controls and provider rate cuts.
- SB 2194: $1 per pack cigarette tax increase providing $700 million for Medicaid; a new hospital assessment program providing $100 million for Medicaid (and $480 million for hospitals); also includes charity care standards for property tax exemptions for non-profit hospitals.

- HB 5007: The Cook County Waiver authorizes the Cook County Health & Hospitals System to provide a limited Medicaid coverage to their patients, prior to the Affordable Care Act 2014 implementation, at no cost to the state; also extends the state's moratorium on Medicaid expansion to 2015.
- SB 3397: Section 25 for Medicaid payments is limited to end the long-time practice of balancing the budget by pushing Medicaid bills into the next fiscal year.

The SMART Act scales Medicaid to fit existing appropriations through spending reductions, utilization controls and provider rate cuts, including:

- Eligibility for adults in the FamilyCare program was reduced to 133% Federal Poverty Level.
- IL Cares Rx was terminated, but "Extra Help/Low Income Subsidy" provides federal assistance to low-income seniors and people with disabilities eligible for Medicare.
- New integrity measures will aggressively target client and provider fraud.
- Enhanced eligibility verification of income and residency through use of private vendor's access to national databases for annual redeterminations.
- Expanded authority of the HFS Inspector General to deny, suspend and recover overpayments and conduct pre-payment and post-payment provider audits.
- Some optional services were eliminated, such as group psychotherapy and adult chiropractic services.
- Utilization controls were placed on certain optional services, such as adult dental services (restricted to emergencies), adult podiatry services (restricted to diabetics) and adult eyeglasses (limited to one pair every two years).
- Medicare standards were adopted for certain services, such as for weight-loss surgery, home health agencies, hospice care, and hospital readmissions and "never events" (the most serious form of medical error).
- Medical necessity reviews were placed on adult and children's prescriptions for any above four per month, with additional prescriptions available based on patients' needs.
- Co-pays were increased to the federal maximum for pharmaceuticals, emergency room non-emergent care and for Federally Qualified Health Centers (FQHCs).
- All provider groups received a rate cut of 2.7 percent, except for physicians, dentists, FQHCs, safety-net hospitals and critical access rural hospitals. Other hospitals than safety-net and critical access hospitals received a rate cut of 3.5 percent.

The 62 issues included in the SMART Act are itemized in the Final Budget Actions Worksheet on SMART Act found in Appendix C of this report or on the Department's Medicaid Legislative Reforms and Budget Web page.

C. Money Follows the Person and Long-Term Care Rebalancing Annual Report

Illinois' Money Follows the Person (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 DHS' 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 Governor's Office Statewide Housing Coordinator who assists with coordination and resource identification of affordable and accessible housing and also the University of Illinois at Chicago – College of Nursing (UIC), which oversees the program's quality

management initiative. UIC has authored significant work on "lessons learned" from the MFP program, including the analysis of risk factors that are associated with higher risk of re-institutionalization. Additionally, HFS and UIC instituted monthly quality webinars for all MFP Transition Coordinators beginning in September, 2012. The focus of the webinars is to provide Transition Coordinators with the tools they need to support MFP participants with complex needs, including chronic health conditions.

In calendar year 2011, the federal Centers for Medicare and Medicaid Services (CMS) 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 which continued operations in calendar year 2012.

States are required by the federal CMS 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 Medical 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, 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, created new MFP marketing and outreach materials and a new program website in Calendar Year 2012 – <www.mfp.illinois.gov>. The website includes numerous program resources, background and also an online web referral form. HFS has been collaborating with the State Long Term Care Ombudsman to coordinate efforts regarding the use of the online referral form. Marketing material includes a fact sheet, FAQ, brochure, fact sheet for nursing home administrators and staff as well as Spanish versions.

During calendar year 2012, the MFP Program completed a total of 292 successful transitions, an increase of 55 transitions over the calendar year 2011 total. The MFP Program completed 788 cumulative transitions by the end of calendar year 2012. The Department anticipates growth in the number of transitions for calendar year 2013 due to a number of factors including:

- The ongoing implementation of two Olmstead related class action lawsuits – *Ligas v. Quinn* and *Colbert v. Quinn*;
- The Administration's Long Term Care Rebalancing Initiative and state facility closures;
- The MFP/ADRC collaboration;
- The expansion of MFP/mental health downstate;
- The continued participation of the DHS Division of Developmental Disabilities in MFP;
- Implementation of the Integrated Care Program/Phase 1 and 2 in suburban Cook Counties.

Calendar Year 2012 MFP Transitions

Population Group	# Transitions
Individuals who are Elderly	60
Individuals with a Physical Disability	99
Individuals with a Serious Mental Illness	54
Individuals with an Intellectual Disability	79
Total	292

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 on the next page.

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	$3,726,290,737	$1,392,410,192	37.37%
2011	$3,903,783,797	$1,526,143,742	39.09%
2012	$4,065,463,503	$1,564,106,843	38.47%

*State Fiscal Year 2012 LTC and HCBS expenditures will fluctuate due to ongoing claim receipts and processing.

IV. INFORMATION SYSTEM IMPROVEMENTS

In 2009, the Illinois Department of Healthcare and Family Services (HFS) initiated a planning effort to replace its 30-year-old Medicaid Management Information System (MMIS). The MMIS is the core system HFS uses to process Medicaid claims, manage provider information, and produce reports for Federal matching funds. The existing MMIS was implemented in 1982 and was 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 aging system that is becoming increasingly difficult to maintain and modify and is unable to meet many of the contemporary needs for cost control in an increasingly care-coordinated environment.

1. Medicaid Management Information System Modernization

HFS has committed that the new MMIS will be designed in accordance with the Medicaid Information Technology Architecture (MITA) developed by the U.S. Department of Health and Human Services (HHS) to increase coordination among states and allow for much greater use of component "off-the-shelf" software. HFS has conducted a MITA State Self-Assessment (SSA) and determined that the current MMIS is at a very low level of MITA maturity and will need to be replaced to meet the demands of modern healthcare IT initiatives from HHS.

HFS began investigating cloud-based solutions to the MMIS challenges, looking to leverage proven, repeatable processes and technologies to not only conserve Illinois' financial resources, but also bring quality solutions to fruition in a much more efficient timeframe. The first major project to come out of this fresh approach will be a new Pharmacy Benefits Management System (PBMS). This first step is essential to improving the management of pharmacy claims, enabling electronic prescribing, improving the financial performance of the drug rebate program and instituting greater utilization review of pharmaceutical activities. The Request For Proposal (RFP) process was kicked off in mid-2012, with an expected implementation date of the fully-functional new PBMS system of mid-2014.

At the same time the PBMS effort is reaching full momentum, another, even more challenging, effort is starting as well. HFS has been in frequent conversations with different state Medicaid agencies throughout the country, as well as the Federal Centers for Medicare and Medicaid Services (CMS), discussing opportunities to model Illinois' new MMIS after that of other successfully-implemented states. In December of 2012, HFS joined in an Inter-Governmental Agreement (IGA) with the State of Michigan to discuss in detail an opportunity to partner with them to implement an Illinois-specific version of Michigan's MMIS. Discussions are under way to investigate the feasibility of implementing a private cloud-based service to serve this purpose, and if successful in doing so, developing a repeatable process that other states can use to join the Illinois-Michigan MMIS alliance, a strategy directly in line with federal requirements. Federal

CMS has also been very supportive of this idea and are considering additional enhanced matching scenarios, above and beyond the 90% level to assist HFS in the process.

2. Enterprise Data Warehouse (EDW)

EDW Upgrade: As planned in the new Optum EDW contract, a comprehensive upgrade of the Teradata system occurred. This was a significant improvement in both hardware and software which resulted in new Teradata equipment and the associated Informatica server software. This change allowed for more space, faster speed, and better tools, such as data security. All milestones in terms of the timeline were successfully met and the change occurred with minimal impact to the end user. It is felt that the contribution of myriad EDW users in the testing of the new system was essential to the successful implementation. EDW "Power Users", those who create complex queries, generally report significant improvements in system performance following the implementation.

EDW Equipment Moved to Illinois Department of Central Management Services: A contract was established between the Illinois Department of Central Management Services (IL-CMS) and HFS that allowed the implementation of the new Teradata system to occur at IL-CMS in Springfield, where the new system and all significant hardware/server components of the EDW will be permanently housed. The highly evolved and supported technical CMS facility provides significant improvements in climate controls, energy redundancy, physical security, and disaster recovery. HFS retains full control of and access to all EDW equipment and data.

CCIP Dataset: The EDW Team created and released unique data sets on Medicaid clients and providers to authorized partner organizations to assist them in the submission of their responses to the Care Coordination Innovations Project (CCIP) and Medicare-Medicaid Alignment Initiative (MMAI) RFPs. The initial data set concentrated on Medicaid clients and providers. Additional data sets focused on pharmacy, emergency, long-term care, and inpatient hospital care. Feedback from partner organizations strongly indicated that the data sets allowed for aggregate summaries of crucial information to more easily occur. Moreover, the data sets have been used frequently by the EDW Team to meet internal reporting requests faster within HFS. Given this very positive outcome the data sets will be expanded in 2013 from containing only 2010 data to a broader span of 2009 – 2011, with regular updates periodically occurring to keep things as current as possible.

Data Analytics Platform: A Data Analytics and Reporting Platform is an advanced, content-rich, and fully Web-enabled system that provides robust analytic capabilities that are substantially superior to the time intensive and limiting efforts of coupling raw EDW data with generic query tools. The EDW Team enhanced its efforts this year of acquiring such a system by hiring a Manager of Data Analytics Platform and engaging leading vendors in the Medicaid healthcare analytics market. This approach will provide useful analytical building blocks such as pre-defined but customizable performance measures that shorten the time to answer complex questions and ensure consistency across users. This type of system will have automatic risk adjustment capabilities and built-in benchmarks for more meaningful analytical comparisons of providers and health plans. Users will be able to easily create queries by simple "point and click" operations and without having to undertake complicated programming and data joins. Both dashboard and ad hoc reporting will provide for a range of data summary and visualization options. It is expected that HFS will select its system in the early part of 2013 with implementation occurring throughout the remainder of the year.

Medicare Data: The EDW Team requested current and historical Medicare data on behalf of HFS to enhance care coordination activities within Illinois. A combined data set of Medicare and Medicaid claims will allow the state and its care coordination providers to better manage Medicare and Medicaid services in the joint effort of providing higher quality services at reduced costs. More specifically, the combined data set will provide HFS with a stronger ability to evaluate the clinical and financial impact of its enrollment broker, MCOs and care coordination

providers. The data will allow the Illinois Client Enrollment Broker (ICEB) to more adequately auto enroll and assign enrollment to more effectively meet the needs of dual eligible clients. What does "and advise enrollment" mean? Similarly, it will better equip MCOs and care coordination providers with the knowledge necessary to connect clients to primary care providers and community services that best fit the clients' needs. In addition to helping partner organizations in the area of risk stratification and to track the delivery of appropriate services provided to clients with chronic diseases, the data will alert providers to gaps in clinical care as well as highlight redundancies in care. At the end of 2012, HFS had been formally approved to receive both current and historical Parts A & B Medicare data and have started the lengthy process of planning the upload of the data into the EDW. HFS is in the final review stages of its application for Medicare Part D data by federal CMS.

3. State Medicaid Health Information Plan

HFS is responsible for the development and implementation of the State Medicaid Health Information Technology Plan (SMHP). In the last year, Illinois received approval of its updated SMHP from federal CMS which described the current state and future phases of the plan. Among other things, the SMHP established the Medicaid Electronic Health Record (EHR) Provider Incentive Payment (PIP) program which pays a 100 percent federally funded incentive payment to eligible Medicaid providers for the adoption, implementation, and meaningful use of certified 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), and specific actions to implement the state's vision for improving patient health through HIT/HIE. 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.
HFS disbursed the first payments under the EHR/PIP program in March 2012 and by mid-December 2012, incentives totaling more than $155 million had been paid to 117 hospitals and 1,721 medical professionals. Additional efforts to encourage provider participation are being planned and the Department estimates payments to providers of more than $700 million over the life of the incentive program, which continues through 2021.

4. New 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). This system will determine eligibility for medical programs, Supplemental Nutrition Assistance Program (SNAP), formerly known as "food stamps" and cash assistance, primarily for Temporary Assistance for Needy Families (TANF) or "welfare" or, before that, AFDC. Additionally, if Illinois establishes its own Health Insurance Exchange under the Affordable Care Act (ACA), the IES will be used to determine eligibility for participation in subsidies under the Exchange. The IES will replace the 30+ year old COBOL mainframe application that was built before there was a functional Internet or relational data bases were widely used.

Development of the IES is being largely defrayed by an enhanced matching rate that the HHS adopted to accelerate the development of systems to facilitate ACA implementation. HHS will offer a 90 percent match on the costs due to Medicaid and a 100 percent match on the costs due to the Exchange. HHS has also suspended the usual allocation rules among programs so that costs are allocable to other programs (in particular, SNAP and Cash Assistance) on only a marginal basis. Moreover, the Federal Department of Agriculture, which administers SNAP, has also agreed to pick up its share. Overall, it is anticipated that Federal revenue will offset more than $135 million of the projected $150 million cost of this long-overdue modernization.

Work on the system started shortly after the passage of the ACA with the creation of an interagency workgroup to address the issue. This group, which now goes by the name of Eligibility Modernization Oversight Group (EMOG), used largely Federal money for a needs assessment and then a strategic planning effort, before contracting with Deloitte Consulting to develop and implement the IES. The EMOG has also worked hard to make sure the design can be expanded to serve as the common eligibility determination vehicle for other programs under the Framework.

The system being implemented is most immediately based on the eligibility system currently used in Michigan, but also draws from New Mexico (where Deloitte is installing a similar system) and several other systems that Deloitte has underway. The initial development work will be done at the Deloitte government services hub where they are involved with eligibility systems from Michigan, New Mexico, Texas, Virginia and several other states, and then moved to the State Data Center in the spring of 2013.

The system installation is proceeding in two phases:

1. Creation of a new, unified front end to the current system is to be completed in time for processing clients under the ACA expansion by October 2013 (for January 2014 enrollment). The new front end will have better access from the Internet and substantially improved tools for processing cases. It will also communicate effectively with the Federally Facilitated Exchange (FFE) that will be processing applicants for subsidized private insurance under the ACA until Illinois establishes its own Exchange. (With authorizing legislation, the Illinois Exchange could be operational in October, 2014).
2. The second phase will replace the existing back-end (those portions of the system that handle on going account management). This process is scheduled for completion by March, 2015, but most will be completed by the end of that calendar year to continue receiving the enhanced federal match.

V. LONG TERM CARE

The monthly average of people served in nursing facilities (NFs) during fiscal year 2012 was over 56,000. The number of facilities serving these people decreased slightly in 2012 (refer to Certification/Decertification topic below for more detail).

Table I, in Section XXII, 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 2010 through 2012. 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 XX, Appendix B and Section XXII, Table VII.

Field Activity

The Department uses registered nurses and medical assistance consultants to perform long term care-related field activities including reviews and oversight to ensure both Nursing Facility (NF) and Supportive Living Facility (SLF) residents receive services that are provided in compliance with state and federal rules. SLF reviews ensure facilities that are being developed prior to their certification for participation in the Medicaid Program comply with Administrative Code 146 Subpart B.

Following certification, field staff performed ongoing monitoring of SLFs which include investigations of complaints received through the SLF Complaint Hotline, annual recertification and technical assistance. NF reviews consisted of conducting rate review protocols and methodologies, and completing post-payment audits to ensure that claims for bed holds are appropriately billed (this will be last year for this due to bed hold payments ending in NFs effective fiscal year 2013) and that residents receiving enhanced exceptional care ventilator rates are receiving appropriate services. Staff

also reviewed facilities that have enrolled only part of their licensed beds (termed Distinct Part facilities) to ensure Medicaid-eligible residents are in Medicaid-certified beds.

Certification/Decertification

During fiscal year 2012, twelve nursing facilities (NFs) and eight Intermediate Care Facilities for Developmental Disabilities (ICF/DD) closed. Of these facilities, three NFs were terminated from participating in the Medicare and Medicaid Programs and all residents were relocated to appropriate settings. The remaining seventeen facilities closed voluntarily. During this same period, four new NFs 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 NFs 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. For calendar year 2012, the MDS Data Repository stored 4,317,120 NF resident assessments. The system received and processed 1,077,063 new records, including admissions, quarterly updates, change of status, and discharge records for 187,787 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 260 reviews on 5,977 nursing facility residents' MDS records; resulting in 215 rate reductions, 3 rate increases and 42 requiring no changes.

VI. 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. HCBS waivers have enabled the State to tailor services to meet the needs of particular target groups. Within these target groups, the State is also permitted to establish additional criteria to further specify the population to be served on a HCBS waiver. The State has the discretion to design the waivers as they choose, within certain parameters. For example, States may choose the number of consumers to serve, the services provided, and whether or not the program is statewide. Federal CMS continuously reviews the waivers and requires each waiver to prove cost-neutral in comparison to institutions. Initial waivers are approved for three years, and waiver renewals have a five year term.

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 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, 96,797 persons were served in HCBS waivers. The growth history of the waiver program from 2007 through 2011 is shown in the chart on the next page.

Waiver Recipients and Expenditures

Waiver Year (WY)	Unduplicated Served	Waiver Expenditures
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 LAG	90,538	$1,277,026,887
WY 2011 Initial	96,797	$1,417,745,118

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. LAG designates final report.

Fiscal year 2012 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). Another three waivers were amended to increase waiver capacity due to an influx of eligible waiver participants. HFS and the operating agencies worked extensively with the National Quality Enterprise, a federal CMS contractor, to design quality improvement systems, create new performance measures while using statistically valid sampling, implement critical incident reporting systems, and develop state remediation processes when non-compliance with performance measures is found. For additional information on the HCBS waivers, please refer to Section II, Appendix B and Section XXII, Table VII of this report.

VII. 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, based on 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, based on 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 chart on the following page shows the annual number and percentage of Illinois teen births covered by Medicaid for fiscal years 2007 through 2009. Fiscal year 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 55.5 percent in 2010 to 58.1 percent in 2011.
- The percentage of HFS covered women who received at least 81 percent of the expected number of prenatal visits increased from 50 percent in 2010 to 51 percent in 2011.
- The number of perinatal depression screenings has continued to increase from 2010 to 2011. Women of reproductive age who received only prenatal screenings increased

  slightly from 33 percent to 34 percent; women of reproductive age who received only postpartum screenings increased from 28 percent to 31 percent; and women of reproductive age who received both prenatal and postpartum depression screenings increased from 18 percent to 20 percent.
- The percentage of HFS covered women of reproductive age diagnosed with depression is substantially higher than non-HFS covered women of reproductive age (11.2 percent and 6.6 percent respectively in 2009). To address this issue, a provider training/engagement initiative on treating perinatal depression continues.

The data above illustrate 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

HFS initiatives focused on improving birth outcomes are described below.

Illinois Healthy Women (IHW) – Planned Pregnancies

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 renew IHW for an additional three-year period or the maximum allowed. Since April 2012, the IHW program has continued to operate under extensions granted to the Department from CMS.

The IHW 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 in 2004 through June 30, 2012, a total of 159,008 unduplicated women received services, reflecting an increase of 26,405 women since June 30, 2011. During waiver year 8, 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 $12,269. Using federal CMS' averted birth methodology, during the first eight years of the waiver, it is estimated that 34,934 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 $318 million for those eight years. In addition to cost savings, IHW experienced the following successes:

- During the first eight years of the waiver, IHW reached its target population. Approximately 53 percent of the women who applied for IHW were ages 19 through 24, and 75 percent had never been pregnant;
- About 74 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 FPL, 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, 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.

CHIPRA-Children's Health Insurance Program Reauthorization Act

The CHIPRA Quality Demonstration Grant includes a focus on improving birth outcomes. A number of interventions have been developed, or are in the process of being developed, including a prenatal electronic data set, a prenatal quality tool for providers, best practices for care coordination/transition, and a public awareness strategy. In addition, CHIPRA is promoting the creation of a statewide perinatal quality collaborative. The interventions developed by CHIPRA will be integrated into the department's maternity program. For more detail refer to the "CHIPRA Quality Demonstration Grant - Improving the Quality of Children's Health Care" topic in this section.

DHS Family Case Management (FCM) Redesign

The DHS Family Case Management (FCM) program, in conjunction with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, is the foundation for an integrated Maternal and Child Health strategy for reducing infant mortality and improving child health. When first implemented, the program demonstrated effectiveness in improving birth outcomes. In the 20 years since implementation, those improvements have diminished, due to the changing healthcare landscape, and significant budget reductions. In June 2012, DHS convened a stakeholders meeting to discuss the need to restructure the FCM program. HFS has been actively involved with DHS, meeting weekly to identify key areas to address. Some of key areas include:

- The target population should be pregnant women and interconceptional women and the focus on children phased out over several years.
- A care coordination approach should be used rather than traditional case management.
- Program duplication should be reduced. Women should only be in one case management program.
- Eligibility should be based on risk.
- Program should be available in areas of high need vs. statewide.
- Program should recognize differences in Cook County and Downstate.

DHS executed 22 new Intensive Case Management (ICM) contracts mid-FY2013 as the initial step towards the redesign of the program.

Strong Start for Mothers and Newborns Initiative – A Center for Medicare and Medicaid Innovation (CMMI) Project

CMMI is interested in testing the effectiveness of evidence-based models for enhanced prenatal care in reducing the rate of premature births among Medicaid-eligible women. The Illinois Public Health Association, the Illinois Maternal and Child Health Coalition and the University of Illinois at Chicago's School of Public Health and College of Nursing (the co-conveners) submitted a proposal to the federal CMMI in June of 2012 for a Strong Start for Mothers and Newborns grant. The Governor's Office and the Illinois Departments of Healthcare and Family Services, Human Services, and Public Health were extensively involved in the project. The Illinois proposal will test two models, Centering Pregnancy and the Maternity Care Home. Premature birth is an important public health issue in Illinois

as well as an important source of preventable Medicaid expenditures. The successful implementation of Strong Start offers promising approaches to improving the health of women and children, while reducing Medicaid expenditures. As of January 2013, CMMI had not made final selection of the awardees.

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); Enhancing Developmentally Oriented Primary Care; Bright Futures as a Standard of Care; Promoting Health: Improving Quality in Obesity Care; Public Awareness Strategy for Preconception, Prenatal and Interconception Care; and Perinatal Consultation to assist the department in developing an initiative to improve birth outcomes. Each of these initiatives is discussed in more detail in this report.

The three year Assuring Better Child Health and Development III (ABCD III) project, funded by the Commonwealth Fund and administered by the National Academy for State Health Policy, concluded in October 2012. The project focus was improving the care coordination system between HFS' primary care providers and DHS' Early Intervention (EI) Child and Family Connections offices. Over the past three years, the Illinois ABCD III project reached approximately 2,000 pediatricians and 3,500 family practices doctors indirectly through newsletters and other outreach efforts. Approximately 250 pediatricians and about 400 family practice doctors were directly reached via face-to-face presentations and Webinars. In addition, approximately 143 EI staff and providers were reached via presentations and Webinars in Adams, Boone, Bureau, Champaign, Cook, DeKalb, DuPage, Effingham, Kane, Kankakee, Kendall, Lake, Macon, Marshall, McHenry, Ogle, Putnam, Sangamon, St. Clair, Vermillion, Washington, Will, Winnebago counties.

Illinois' ABCD III project yielded a number of accomplishments. Among Illinois' achievements is its developing electronic data exchange, which will allow for an electronic referral initiation and feedback system. Illinois implemented a first round of quality improvement cycles in four Early Intervention (EI) regions to systematize the communication loop between primary care providers (PCPs) and EI through the use of standardized EI referral and feedback forms. The ABCD III team developed on-line training modules for EI staff regarding forms and protocols for completing the communication loop back to the PCP. The team also developed a curriculum for pediatricians engaged in the pilots to obtain Maintenance of Certification Part 4 (MOC4) credit. Finally, Illinois implemented the referral and feedback process for community service providers who refer to EI that loops in the PCP.

Other notable ABCD III policy improvements and achievements include:

- *Electronic Data Exchange*. Illinois is developing its data exchange to allow for an electronic referral initiation and feedback to the referring provider. To assist in this effort a series of Joint Application Design (JAD) meetings, convening information technology staff from DHS and the HFS, have been held.
- *Care Coordination Toolkit.* The Illinois team has completed a draft of a Care Coordination toolkit, which has been vetted by HFS and several stakeholders. Care Coordination protocols will also be featured prominently in the upcoming revised Handbook for Providers of Healthy Kids Services, which ICAAP recently updated and is currently going through review prior to publication.
- *HIPAA/FERPA privacy and confidentiality provisions.* Illinois' consent process, outlined below, and its permits are HIPAA/FERPA compliant.
    - The PCP to send information about the objective developmental screening or reason for referral to EI.
    - EI to send information back to the PCP regarding the outcome of the referral.
    - HFS to facilitate the information exchange between the PCP and EI.
    - HFS to use the data exchanged for purposes of care coordination measurement.
- *Other policy enhancements.* The Illinois team accomplished a number of other policy improvements including:
    - Care coordination protocols, including screening and referral will be incorporated into protocols for both home visitors and childcare workers in Illinois.
    - The electronic data exchange will send the PCP not only initial referral information, but also an iterative update when changes are made to an IFSP.
    - The Illinois CHIPRA demonstration grant, as part of its quality improvement, has begun to use the MOC4 process created for Illinois ABCD III medical homes.
    - CHIPRA pilot practices are being offered access to the Statewide Provider Database (SPD) which will provide easy access to community resources through the Medicaid provider portal.
    - DHS included ABCD III referral processes in their recent updates to the Child and Family Connections (CFC) Procedure Manual.

Healthy Kids

The federally required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is the nation's largest preventive child health initiative. In Illinois, the initiative is named "Healthy Kids." 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, Third Edition (2008),* published by the American Academy of Pediatrics. *Bright Futures*, the most current version of the guidelines and considered the gold standard for pediatric care, is a set of principles, strategies and tools that are theory-based, evidence-driven, and systems-oriented, that can be used to improve the health and well being of all children. The mission of *Bright Futures* is to promote and improve the health, education and well-being of infants, children, adolescents, families and communities.

Bright Futures uses a developmentally based approach to address children's health needs in the context of family and community. The cornerstone of *Bright Futures* is a comprehensive set of health supervision guidelines developed by multidisciplinary child health experts – ranging from providers and researchers to parents and other child advocates – that provide a framework for well-child care from birth to age 21.These guidelines are designed to present a single standard of care and a common language based on a model of health promotion and disease prevention.

HFS entered into an agreement with the Illinois Chapter of the 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 and Quality of Children's Health Care

The Children's Health Insurance Program Reauthorization Act (CHIPRA) established a core set of 24 children's health quality measures. These measures are voluntary for state reporting to the Centers for Medicare and Medicaid Services (CMS) via the CHIP Annual Reporting Template System (CARTS). However, Illinois is required to report the CHIPRA core measures under the terms of the CHIPRA Quality Demonstration Grant awarded to Florida and Illinois in 2010. Illinois first reported on measures in the core set in FFY 2010. At that time, 10 measures were reported. In the current FFY 2012, Illinois reported on 20 measures. CHIPRA core measures are included in the Secretary's Annual Report on the Quality of Care for Children in Medicaid and CHIP. The most recent report is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2012-Ann-Sec-Rept.pdf Illinois is working to report the full core set for federal fiscal year 2013.

The initial core measure set with the current HFS reporting status of each measure to federal CMS is identified in the chart below.

	Measure	**Status**
1	Timeliness of Prenatal Care	Reported
2	Frequency of Ongoing Prenatal Care	Reported
3	Live Births Weighing Less than 2,500 Grams	Reported in 2011. Not report in 2012 due to lack of Vital Records data.
4	Cesarean Rate for Nulliparous Singleton Vertex	Not yet programmed
5	Childhood Immunization Status	Reported
6	Adolescent Immunization Status	Reported
7	Body Mass Index Assessment for Children/Adolescents	Reported
8	Developmental Screening in the First Three Years of Life	Reported
9	Chlamydia Screening	Reported
10	Well-Child Visits in the First 15 Months of Life	Reported
11	Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Reported
12	Adolescent Well-Care Visits	Reported
13	Percentage of Eligibles that Received Preventive Dental Services	Reported via CMS 416
14	Children/Adolescent Access of Primary Care Practitioners (PCP)	Reported

	Measure	Status
15	Appropriate Testing for Children with Pharyngitis	Reported
16	Otitis Media with Effusion (OME) – Avoidance of Inappropriate Use of Systemic Antimicrobials	Retired by CMS
17	Percentage of Eligibles that Received Dental Treatment	Reported via CMS 416
18	Ambulatory Care – Emergency Department Visits	Reported
19	Pediatric Central Line-Associated Blood Stream Infections	Reported by CDC
20	Annual Percentage of Asthma Patients With One or More Asthma-Related Emergency Room Visit	Reported
21	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Reported
22	Annual Pediatric Hemoglobin (HbA1c) Testing	Not yet programmed
23	Follow-Up After Hospitalization for Mental Illness	Reported
24	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0H, Child Version	Not reported

Long before the CHIPRA core measure set was introduced, the Department monitored 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. A number of these measures are included in the CHIPRA core set. 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: Title 19 and Title 21 Continuously Enrolled			
Description	**Calendar Yr. 2009**	**Calendar Yr. 2010**	**Calendar Yr. 2011**
15 mo. olds with 6 or more well child visits	68.7%	70.8%	71.6%
15 mo. olds with zero well child visits	2.8%	2.6%	2.6%

Source: HFS Executive Information System, Data as of November, 2012

Well Child Visits at ages 3, 4, 5 and 6. This HEDIS measure calculates the percentage of children between three and six years of age who had at least one well child visit before the target birth date.

Well Child Visits at 3, 4, 5, and 6 Years of Life: Title 19 and Title 21 Continuously Enrolled						
Calendar Year	**Measure**	**3 Yrs.**	**4 Yrs.**	**5 Yrs.**	**6 Yrs.**	**Total**
2009	Eligible Population	90,295	85,509	81,505	78,983	336,292
	Population # with at least 1 WCV	66,881	63,924	64,456	45,962	241,223
	Population % with at least 1 WCV	**74.1%**	**74.8%**	**79.1%**	**58.2%**	**71.7%**
2010	Eligible Population	95,279	92,488	87,867	84,283	359,917
	Population # with at least 1 WCV	70,709	69,093	68,538	48,925	257,265
	Population % with at least 1 WCV	**74.2%**	**74.7%**	**78.0%**	**58.0%**	**71.5%**
2011	Eligible Population	95,050	96,104	93,612	89,147	373,913
	Population # with at least 1 WCV	70,604	71,604	72,465	51,290	265,963
	Population % with at least 1 WCV	**74.3%**	**74.5%**	**77.4%**	**57.5%**	**71.1%**

Source: HFS Executive Information System, Data as of November, 2012.

Objective Developmental Screening. This CHIPRA core 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: Title 19 and Title 21 Continuously Enrolled					
Calendar Year	**Measure**	**1 Yr.**	**2 Yrs.**	**3 Yrs.**	**Total**
2009	Eligible Population	93,071	94,102	90,745	277,918
	Population # with at least 1 ODS	40,698	30,295	17,746	88,739
	Population % with at least 1 ODS	**43.7%**	**32.2%**	**19.6%**	**31.9%**
2010	Eligible Population	92,940	94,565	96,134	283,639
	Population # with at least 1 ODS	49,014	38,855	26,042	113,911
	Population % with at least 1 ODS	**52.7%**	**41.1%**	**27.1%**	**40.2%**
2011	Eligible Population	89,985	93,192	95,552	278,729
	Population # with at least 1 ODS	54,840	46,404	33,185	134,429
	Population % with at least 1 ODS	**60.9%**	**49.8%**	**34.7%**	**48.2%**

Source: HFS Executive Information System, Data as of November, 2012

Childhood Immunization Status. The Department calculates immunization status of children at 24 and 36 months of age. The percentage of 36 month olds with Combo 1 immunizations over the past three years is reflected in the table below.

Immunizations Status* at 36 Months of Age: Title 19 and Title 21 Continuously Enrolled		
Calendar Year	**Measure**	**Number and Percentage**
2009	Eligible Population	89,610
	Population Fully Immunized	61,577
	Fully Immunized %	**68.7%**
2010	Eligible Population	95,100
	Population Fully Immunized	67,450
	Fully Immunized %	**70.9%**
2011	Eligible Population	95,082
	Population Fully Immunized	67,023
	Fully Immunized %	**70.5%**

***** Combo 1: (4) DTaP; (3) IPV; (1) MMR; (3) Hib; (2) Hep B [(4-3-1-3-2)]
Source: HFS Executive Information System, November, 2012

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 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) EPSDT Participation Ratio	**Number of Title XIX (Medicaid) Enrolled Children Under 21**	**All Population EPSDT Participation Ratio**	**Number of All Enrolled Children Under 21**
2010**	77.0%	1,572,577	77.9%	1,673,498
2011	76.0%	1,613,042	76.9%	1,715,171

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. Data reported for 2010 and thereafter are for "Total Individuals Eligible for EPSDT for 90 Continuous Days."

CHIPRA Quality Demonstration Grant - 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. HFS is working to test, implement, operationalize, and integrate interventions to improve the quality of children's health care. For more information on the CHIPRA Grant refer to Section XVIII, Quality Assurance, Utilization and Control.

VIII. 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. In fiscal year 2012, adult dental coverage is limited to diagnostic and restorative services.

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 2012 HEDIS results. The Department's 2012 Annual Dental Visit HEDIS measurement shows that 56.38 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 51 percent in 2010 and 54 percent in 2011.

Dental Program Expands Match Claiming

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. In 2010, 17 local health departments participated in the process and received over $1 million in federal match dollars back to the local oral health program.

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.
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 statewide. A total of 2,659 providers have been trained, including residents under the supervision of a physician, primary care providers and other health professionals. There were a total of 329 training sessions with staff from private clinics, residency programs, FQHCs/rural health clinics and local health departments participating. 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 2011, over 13,000 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 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 2012, payments for dental care totaled over $277 million. DentaQuest reported that 890,233 individuals under the age of 21 received over 6.8 million dental services, for a total expenditure of approximately $211 million. For the same time period, 270,601 individuals ages 21 and over received 1.86 million dental services for a total expenditure of approximately $66 million.
More information regarding the HFS Dental Program may be obtained at the following Department and DentaQuest websites: http://www2.illinois.gov/hfs/MedicalProvider/Dental/Pages/default.aspx or <http://www.dentaquestgov.com>

IX. CARE MANAGEMENT

Managed Care

At this time, Illinois' Managed Care program consists of three delivery systems: the Integrated Care Program (ICP), 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. Over the next year, the Department will be implementing additional managed care models to test innovative care coordination models, such as the Care Coordination Innovations Project.

Integrated Care Program (ICP)

The Department awarded contracts to Aetna Better Health and IlliniCare Health Plan (Centene) in September of 2010 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 enrolled in the ICP. The ICP was the Department's first mandatory managed care program and was initially met with some resistance from both providers and enrollees. The Department, Aetna Better Health and Centene worked extensively to recruit providers into the ICP networks. Enrollment into the ICP began on May 1, 2011 and the enrollment roll-out was completed on January 1, 2012.

The ICP 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 provide a more coordinated medical approach and to keep him/her healthier. 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 his/her health needs, whether those needs are physical, behavioral or social.

The five-year contracts with Aetna Better Health and Centene were estimated to cost an estimated $450 million annually in capitation payments. The savings/cost avoidance estimates over the five-year contracts are estimated to be $200 million, as a result of (1) 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 (2) 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 covered through ICP. In calendar year 2012, HFS spent $324.4 million in capitation payments to these two MCOs.

ICP Services

Service Package I of the ICP covers 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. Case management, an essential part of the ICP, is also a required service.

Service Package II went into effect on February 1, 2013. Under Service Package II, covered services 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 waivers. Service Package II reinforces Illinois' system of consumer-directed care for persons with disabilities.

Service Package 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 in need of care management or disease management are identified through the use of predictive modeling, referrals and 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 who are 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 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 conducting enrollee assessments, developing an enrollee care plan in collaboration with the enrollee and their caregivers, and communicating and coordinating care in a manner that ensures the enrollees' physical and behavioral health needs are met. The decision of what type of health care the member receives is ultimately in the hands of the member as 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 Centene contain 31 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 ensuring members follow up with a provider within 30 days after receiving a mental health diagnosis, follow up with a provider within 14 days after an emergency room visit, and management of chronic illnesses such as diabetes with appropriate care.

Primary Care Case Management (PCCM) – Illinois Health Connect

The PCCM, Illinois Health Connect (IHC), has been fully operational since November 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, 2012, 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 $600 million since the program's inception. In addition, through the implementation of the Care Coordination Innovations Project, the Department will begin to test models of care that enhance the PCCM program and work to better coordinate care for its members.

The IHC program is mandatory for most persons covered by the Department's Medical Programs, including children and adults enrolled through the All Kids program 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 at this time.

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 and expansion of a provider network 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 specialists 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 where the Voluntary Managed Care program is available, eligible enrollees may opt out of IHC to enroll with a Managed Care Organization (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 has made available the following quality tools for use by PCPs in their practices:

- *Panel Rosters* – The IHC Panel Roster is a listing of all the patients that are currently linked to that PCP for a medical home. Panel rosters help providers manage their patients' care by identifying which patients are due for screening or checkups based on HFS claims data.
- *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 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 HFS. PCPs are able to submit referrals for their patients to see other enrolled PCPs. Physicians and specialists who 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

The Voluntary Managed Care program has been a healthcare option for Medical Assistance Program participants in Illinois since 1976, and continues to be a choice even with the implementation of the PCCM program. Overall, MCO enrollment increased 17 percent during fiscal year 2012, from 213,420 participants at the beginning of the fiscal year (July 1, 2011) to 249,617 at the end of the fiscal year (June 30, 2012).

The Voluntary Managed Care program is available to participants residing in the counties of Adams, Brown, Cook, Henderson, Henry, Jackson, Kane, Knox, Lee, Livingston, Madison, McHenry, McLean, Mercer, Peoria, Perry, Pike, Randolph, Rock Island, St. Clair, Scott, Tazewell, Warren, Washington, Williamson and Woodford. Medical Assistance program participants residing in these counties may opt out of the IHC and choose an 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 HFS 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, an HMO, Meridian Health Plan, an HMO, and Family Health Network, an 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, community based mental health providers 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 management 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 MCO's case management and disease management programs and systems. The MCOs are required to submit their 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, including each Plan's case and disease management systems. The EQRO reports can be found at http://www2.illinois.gov/hfs/ManagedCare/Pages/EQRTR.aspx.

Other Care Coordination Initiatives Underway

2013 will see an ambitious roll-out of care coordination for most of the Medicaid populations. Specific planning was underway in 2012 with respect to:

- Care Coordination Innovations Project
- Medicare-Medicaid Alignment Initiative

These projects are described in Section II, The Future of Medicaid – Care Coordination, of this report and on the Care Coordination Innovations Project page on the HFS Web site.

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) Line and a coordinated provider network aimed at proving short-term, crisis intervention and stabilization services, level of care transitional services; and discharge planning services for SASS eligible individuals. In fiscal year 2012, the SASS program served in excess of 26,000 unique children and youth while the three departments expended over $30 million in funding 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/

X. MEDICAID PROVIDER ASSESSMENT PROGRAM

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. The availability of funds generated by the Provider Assessment Program 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 ($9.7 billion in provider taxes and $9.4 billion in FFP).

Provider assessments by provider class and year of assessment, fiscal years 1992-2012, in millions of dollars

	Provider assessments			
Fiscal year	Total	Hospitals	Nursing facilities	ICFs/MR
Total	$ 9,695.50	$ 7,827.00	$ 1,465.10	$ 403.40
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
2012	1,028.8	890.9	117.6	20.3

Source: Bureau of Program and Reimbursement Analysis.

[1] Intermediate care facilities for the mentally retarded.

During fiscal year 2012, nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs/MR) continued to be taxed.

The $1.50 per licensed day bed tax on NFs has generated nearly $56 million in tax revenue annually. Beginning fiscal year 2012, there was an additional tax on NFs of $6.07 per occupied bed, which generated $61.7 million.

The 5.5 percent tax on the adjusted gross revenues of ICFs/MR generated nearly $20.3 million in tax revenues and the hospital provider tax totaled approximately $891 million.

XI. 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 Provider Enrollment or < http://www.hfs.illinois.gov/enrollment/>

At the end of fiscal year 2012, a total of 73,580 providers were enrolled with the Department, representing an increase of 7,634 providers over fiscal year 2011 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/

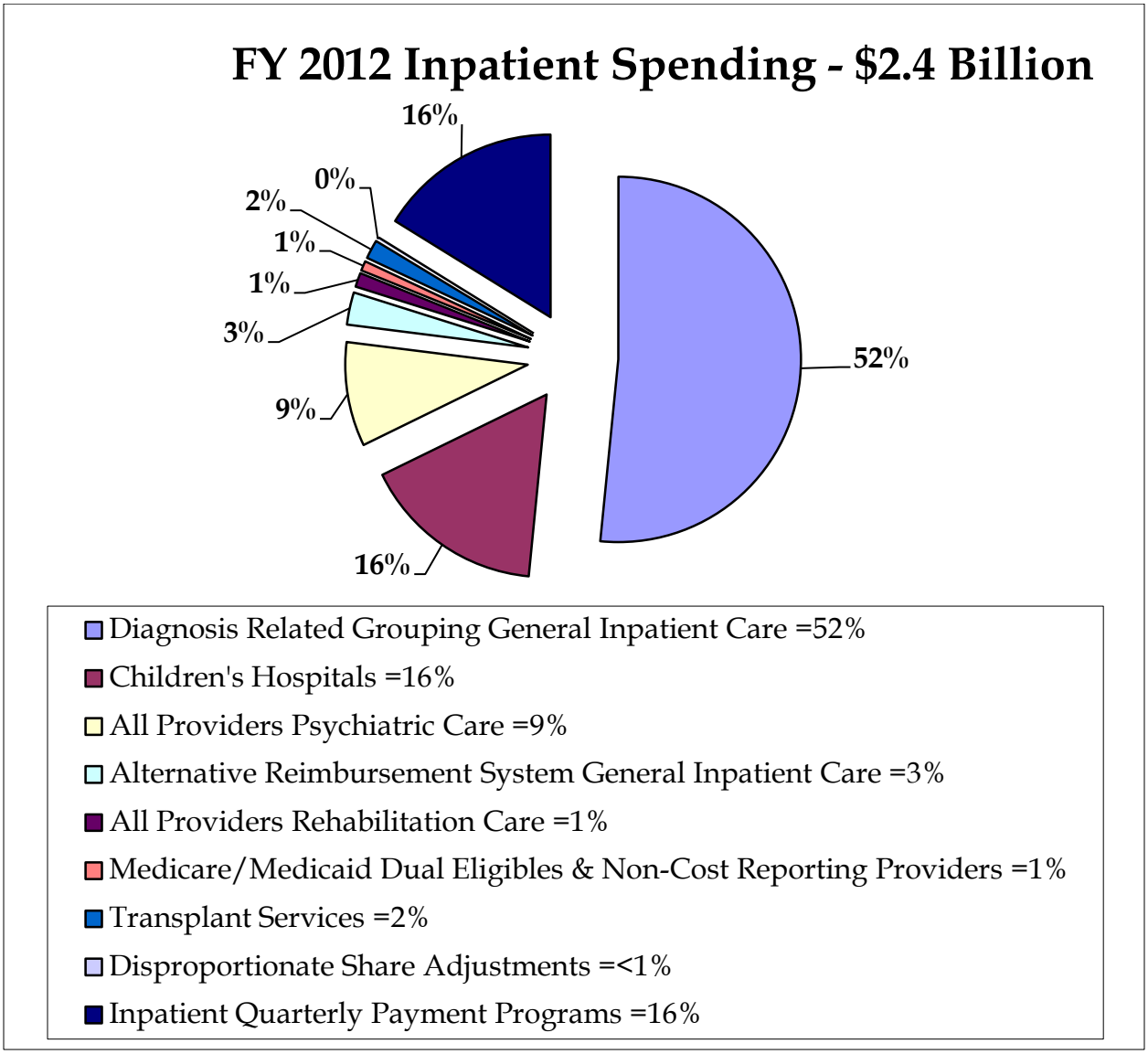
More detailed reimbursement information on several provider types is described in the following sections.

XII. REIMBURSING HOSPITALS

Inpatient Hospital Services - General Revenue Fund (GRF)

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. Information on HFS' rate reform efforts can be found in Section II, The Future of Medicaid – Care Coordination, of this report.

Date of service spending levels for base reimbursements in fiscal year 2012 decreased 3.5 percent to $2.04 billion from the 2011 amount of $2.12 billion. The average length of stay for all providers and claims remained the same and there was approximately a three percent increase in the average payment per day for the same time period. The overall decrease in inpatient spending can be attributed to an increase in the outlier threshold, effective January 1, 2011. Outlier payments are made on hospital inpatient admissions that deviate significantly from established norms, i.e., excessively long lengths of stay or expensive admissions. This increase to the outlier threshold factor has the effect of lowering the amount of outlier liability. While the base payments decreased by about 3.5 percent, there was a 4 percent corresponding change in static payments. Consequently, the overall decrease in reimbursement for hospitals was 2 percent, down to $2.44 billion from $2.50 billion in fiscal year 2011.



Disproportionate Share Hospitals (DSH)

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 2012, 50 hospitals qualified for the DSH adjustment with a total spending of $5 million. In addition, five 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 $96.9 million in federal fiscal year 2012 and the University of Illinois was paid $23.3 million. The average DSH payment for hospitals other than state operated psychiatric facilities and the University of Illinois was $7.44 per DSH day in fiscal year 2012, a decrease from the $7.45 per DSH day paid in fiscal year 2011.

In accordance with federal guidelines set forth in the *Omnibus Budget Reconciliation Act (OBRA) of 1993*, 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 2012, 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, 86 hospitals qualified for MPA payments with rates ranging from $47.17 to $314.53. Twenty children's hospitals received MHVA payments of $226.44 per day, and 66 other hospitals received MHVA payments of $113.22 per day.

Outpatient Hospital Services – GRF

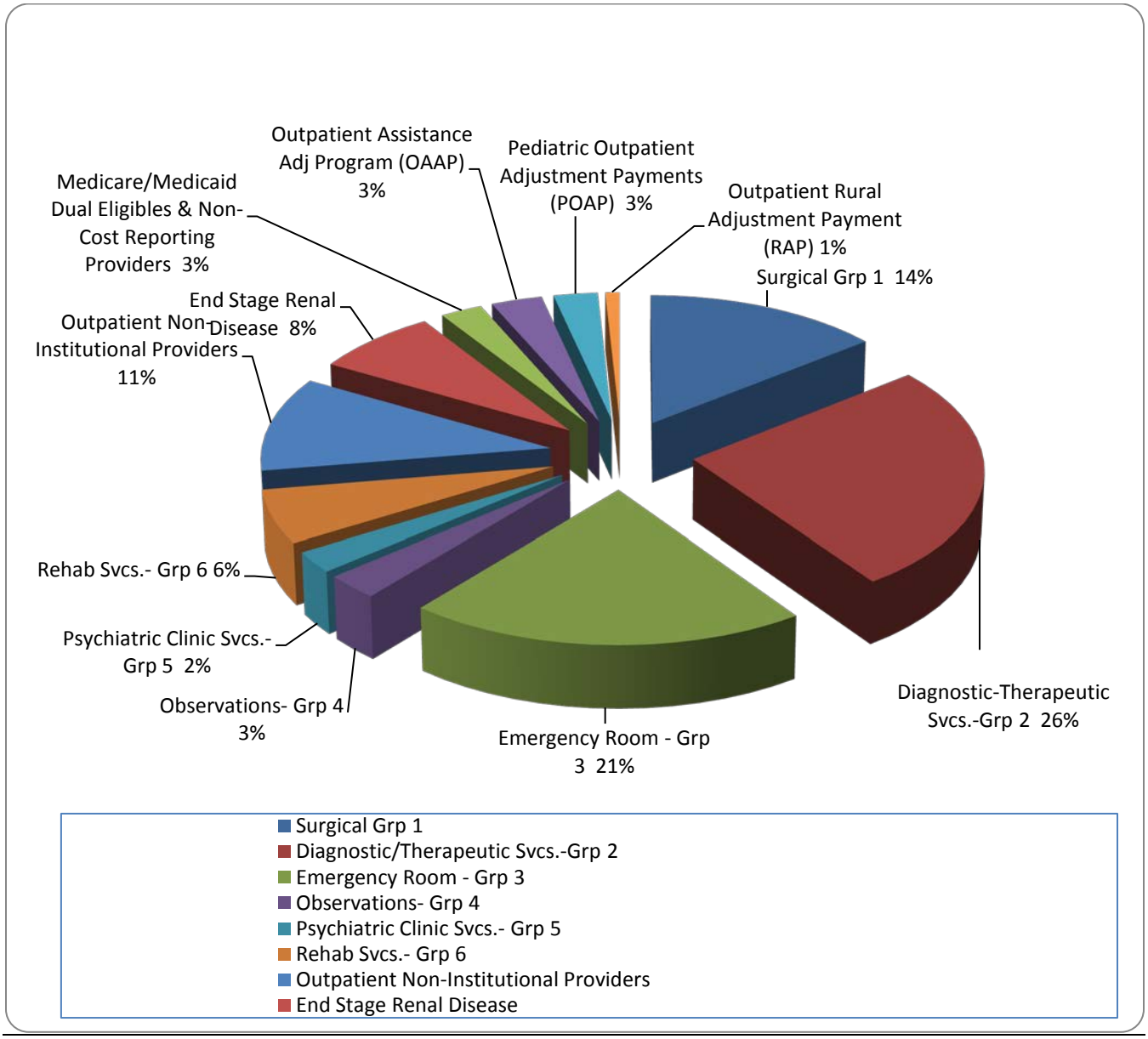
Ambulatory Care Services

Outpatient spending for fiscal year 2012 increased approximately 2 percent, primarily related to growth in eligibility.

Total date of service outpatient spending for fiscal year 2012 was $750 million. The majority of general hospital outpatient claims fall into one of the following six Ambulatory Procedure 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 graph on the following page depicts total Outpatient spending in fiscal year 2012, 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 2012 Total Outpatient Payments by Category



Inpatient Static Payments

Critical Hospital Adjustment Payments

The Critical Hospital Adjustment Payment (CHAP) program, created in fiscal year 1996, provides 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 2012, approximately $229.6 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 2012, this program distributed approximately $42.5 million to 38 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 2012, four qualifying rehabilitation hospitals received a little over $11.8 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 2012, 30 qualifying hospitals received approximately $159.6 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 2012, 88 qualifying hospitals received close to $15.7 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 2012, 15 children's hospitals received approximately $10.8 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 2012, the program paid approximately $4.4 million to six acute care facilities with specialized psychiatric care units.

Rural Adjustment Program

The Rural Adjustment Program provides 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 2012, a total of 47 providers qualified for the inpatient portion of the program with payments totaling approximately $550,000.

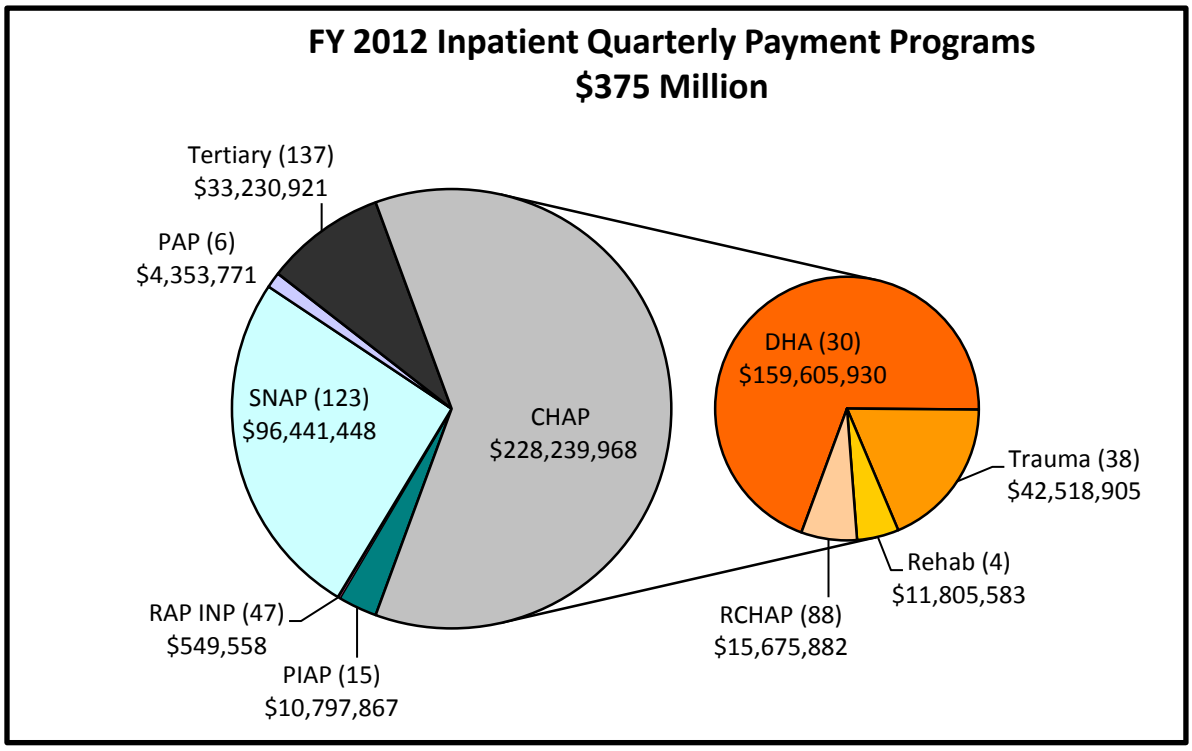
Safety Net Hospital Adjustment

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 2012, a total of 123 providers qualified for the program with payments totaling $96.4 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 2012, with payments totaling approximately $33.2 million.

Total GRF inpatient static payments made for each program and 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 2012, OAAP payments totaled $23.1 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 2012, the program paid $19.9 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 2012, almost $12 million was paid out to Illinois' 63 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, was repealed under the SMART Act [Public Act 097-0689] effective July 1, 2012. The total statewide awards under the program were based on the level of funding appropriated by the General Assembly, which increased from $6.8 million in fiscal year 1997 to $27.6 million in fiscal year 2012.

XIII. 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), based clinical information. MDS-based clinical information is used to update 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 $133.10 on June 30, 2012. Additionally, the SMART Act [P.A. 097-0689] directs the Department to redesign its rate methodology by January 1, 2014 based on the Federal RUG-IV 48 grouper methodology.

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 2012, 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. Four newly certified facilities received initial rates in FY12.
- *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 85 facilities in fiscal year 2012.
- *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 no homes in fiscal year 2012.

XIV. REIMBURSING MANAGED CARE ORGANIZATIONS

Managed Care Organizations

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.

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. Pharmacy services will be added back to the capitation in April 2013.

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, mental 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 fee is paid to PCPs enrolled in IHC on a capitated basis for each person whose care they are responsible to manage. The fees are $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 based on a per member/per month amount and performance of various contractual requirements that were the result of the competitive procurement process.

IHC Bonus Payment for High Performance Program

In 2008, the Department established an annual IHC 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.

Payments issued under the bonus program 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
- Lead Screening (New measurement under Bonus Program Year 2011)

The HEDIS 50th percentile is the benchmark for these measurements, with the exception of the Developmental Screening, which is established by the Department. If a PCP meets or exceeds the benchmark for a particular measured service, a bonus payment will be made for each patient on their panel that received the measured service.

Under the most current bonus program, Calendar Year 2011, a total of 4,369 PCPs, at 4,740 sites, qualified for a bonus payment. The bonus payment was $25 per qualifying enrollee, per qualifying event. In total, there were 214,396 qualifying events, resulting in over $5.3 million in bonus payments to qualifying PCPs.

As a result of the IHC bonus payment program, participating PCPs have implemented quality improvement initiatives within many of their practices, resulting in increased access to care and improved quality of care for enrolled enrollees.

Managed Care Quality Assurance

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

XV. REIMBURSING PHARMACY

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 2012, 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. The Department continued its 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 14 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

As part of the SMART Act discussed in Section III, Other 2012 Initiatives, the Department began phasing in medical necessity reviews of prescriptions in excess of four per month beginning in fiscal year 2013. As of the publishing of this report, phase in was down to adult scripts over 5 per month. Additional on the medical necessity reviews of prescriptions in excess of four per month is available on the Department's 2013 Medicaid Pharmacy Program Web page.

Reimbursement Rates

During fiscal year 2012, the reimbursement rate for single-source medications (i.e., brand name) is Wholesale Acquisition Cost (WAC) plus 1 percent plus a dispensing fee of $3.40. Multi-source medications (i.e., generics) are reimbursed at WAC plus 1 percent plus a dispensing fee of $6.35. The Department's maximum price for each drug continues to be the lesser of WAC plus 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 2012, the Department collected approximately $18 million in state supplemental rebates from drug manufacturers. Although rebate collections decreased (they were $37 million in FY2011), rebates as a percentage of spending increased. The decrease in rebate collections was due to the less overall drug spending related to FY12 state underfunding of the drug line and the increased shift to generic drugs, which do not get supplemental rebates. Currently, federal and supplemental rebates combined equate to approximately 48 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://www2.illinois.gov/hfs/MedicalProvider/preferred/Pages/default.aspx

XVI. 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 308,500 Illinois school children participating in the School-Based Health Services program received direct medical services during fiscal year 2012. Local Education Agencies received reimbursement of more than $167.5 million for their costs to provide these services and more than $53.9 million for their administrative costs. In addition, the School-Based Health Services program generated more than $1.2 million in revenue for the state. For more information visit: <http://www.sbhsillinois.com/>

XVII. REIMBURSING OTHER PROVIDERS

Rural Health Clinics (RHCs)

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 2012, the RHC program had 249 sites in Illinois. This reflects an increase of 15 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 2012, medical encounter rates for RHCs ranged from $46.98 to $90.51 and behavioral health encounter rates ranged from $52.09 to $62.47.

Federally Qualified Health Centers (FQHCs)

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 CMS. During fiscal year 2012, there were 394 FQHC sites throughout Illinois. This reflects an increaseof 42 sites from the previous fiscal year. As with RHCs, FQHCs are also reimbursed a PPS based encounter rate. In fiscal year 2012, medical encounter rates for FQHCs ranged from $88.83 to $134.32 and behavioral health encounter rates ranged from $37.28 to $56.73.

State Hemophilia Program[1]

The Illinois State Hemophilia Program provides assistance to eligible patients to obtain antihemophilic factor, annual comprehensive visits and other outpatient medical expenses related to the disease. This program is completely state funded. In fiscal year 2012, out of 227 enrolled participants, 146

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

participants received financial assistance for hemophilia treatment, at a cost of approximately $17 million. Additional information about the State Hemophilia Program can be found in Appendix A of this report or in the Chapter 100 Handbook available on the Department's Web site.

Illinois Sexual Assault Survivor Emergency Treatment Program[1]

The Illinois Sexual Assault Survivor Emergency Treatment Program pays emergency outpatient medical expenses and 90 days of related follow-up medical care for survivors of sexual assault. This program is completely state funded. In fiscal year 2012, approximately $2.2 million was paid for medical services provided to 1,117 sexual assault survivors. Additional information on this program can be found in Appendix A of this report.

State Chronic Renal Disease Program [1]

The Illinois State Chronic Renal Disease program assists Illinois residents who have been diagnosed as having chronic renal disease at the stage of irreversible renal impairment requiring a regular course of dialysis to maintain life. This program is completely state funded. The expenditures paid for fiscal year 2012 totaled slightly over $425,000 for 199 clients receiving services. Additional information on this program can be found in Appendix A of this report or at State Chronic Renal Disease Program on the Department's Web site.

Non-Emergency Transportation Services

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

The Department's Non-Emergency Transportation Services Prior Approval Program (NETSPAP) has been in operation since 2001. The program allows the Department to maintain standards and controls necessary to ensure that the payment of transportation services complies with federal requirements. The program ensures: 1) transport is to a covered medical service; 2) transport is via the most cost effective mode, meeting the medical needs of the participant, and; 3) the participant is being transported to the closest appropriate medical provider. The NETSPAP is currently administered by First Transit, Inc. The administrator is responsible for the screening and prior approval adjudication process for all non-emergency medical transportation. During the fiscal year 2012, the program authorized 549,280 non-emergency transportation transactions.

P.A. 095-0501 requires drivers and employee attendants, of medicar and service car transportation providers, to complete an HFS approved Safety Training Program prior to transporting participants of the Department's Medical Programs. All enrolled providers of non-emergency medicar and service car transportation must certify the drivers and employee attendants have completed an approved Safety Training Program. To ensure compliance, the Department's Office of Inspector General (OIG) conducts compliance audits to review transportation provider certification compliance. If current certifications are not compliant for the drivers and attendants, the payments made for transport of participants, covered under Department's Medical Programs, may be recovered from the enrolled non-emergency transportation provider. A current listing of approved Safety Training Programs can be found on the Department's Web site at Provider Enrollment or http://www.hfs.illinois.gov/enrollment/

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

XVIII. QUALITY ASSURANCE, UTILIZATION AND CONTROL

CHIPRA Quality Demonstration Grant - 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. HFS is working to test, implement, operationalize, and integrate interventions to improve the quality of children's health care in the following four areas:

1. Child Health Quality Measures

The Center for Medicare and Medicaid Services (CMS) released a core set of child health measures in February 2011. The department was collecting, analyzing and reporting on many of the core measures and continues to develop the capacity to report on the remaining measures and to use those measures to drive quality improvement at the state level, within health plans and among providers.

Accordingly, during 2012, Voluntary Managed Care Organization (VMCO) contracts were amended to include the requirement to report applicable CHIPRA core measures. The PCCM contract currently requires reporting on four of the CHIPRA core measures, and subsequent contracts will include additional applicable CHIPRA core measures. The status of reporting on the core measure set is addressed under "Measuring Progress and Quality of Children's Health Care" in Section VII, Maternal and Child Health, of this report.

CMS and the Agency for Healthcare Research and Quality (AHRQ) are charged with enhancing the initial core set by adding measures to fill identified gaps and improving upon measures currently in the core set. CMS and AHRQ have contracted with seven Centers of Excellence (CoEs) to develop these new and improved measures for the Pediatric Quality Measures Program (PQMP). Additional measures are expected to be added to the core set during 2013 and annually, thereafter. Illinois participates in the PQMP and works directly with several CoEs to provide state-level input into the development of new and improved measures.

Under the CHIPRA grant, HFS also proposed to identify, develop and test new children's health care quality measures for consideration at the national level. During 2012, HFS proposed the development of two new measures and with the assistance of the National Committee on Quality Assurance (NCQA), convened a Measure Advisory Panel (MAP) to provide expert opinion and consultation on the proposed measures. The MAP recommended that HFS not pursue either measure due to lack of guidelines and evidence to support the processes/practices being measured. The MAP recommended that HFS conduct a study on one of the measure topics, follow-up after an emergency department visit, and HFS has convened a workgroup to address this issue.

Through HFS' experience in attempting to develop new measures and involvement with the PQMP, HFS learned that new measure development requires extensive resources beyond those available from the CHIPRA grant. As a result of this experience, HFS reconsidered the development of new measures and will continue to collaborate with the CoEs under the PQMP and provide data and state-level input in developing new measures for the CHIPRA core set.

2. 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 is working to 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.

Technology solutions include:

- Making the DCFS Statewide Provider Database available to CHIPRA medical home practices to facilitate care coordination.
- Working with the Illinois Health Information Exchange (ILHIE) on a use case to test the feasibility of a Prenatal Electronic Data Set. The purpose of this data set is to make prenatal information available to hospitals and other providers electronically at any time to improve care coordination of labor/delivery.
- Working to expand an automated referral process developed under another grant to CHIPRA medical home providers to facilitate care coordination.
- Promoting the ILHIE Direct (direct secure messaging) product to CHIPRA and other HFS providers.

3. Improving and Enhancing Medical Homes

During late 2011 and early 2012, HFS and the Illinois Chapter of American Academy of Pediatrics (ICAAP) recruited 63 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. This baseline data was used by ICAAP to develop training specific to the identified needs. Fifty-one practices are now involved in the CHIPRA medical home initiative and receive medical home resources. Resources include participation in a learning group, webinars, regular technical assistance, quality improvement initiatives, and training. Participating practices are able to choose resources from a menu of options.

A workgroup was convened in late 2012 to develop recommendations for HFS policies/incentives to promote the further development of medical homes among practices serving Medicaid/CHIP participants. The workgroup will review recent literature/information on the effectiveness of medical homes, incentives adopted and lessons learned by other states and develop medical home recommendations for HFS consideration during 2013.

4. 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, and
- Recommending prenatal guidelines, referral protocols, and education.

  During 2012, CHIPRA submitted the prenatal electronic data set to ILHIE for testing as a use case. Work on this initiative will continue in 2013. CHIPRA stakeholders also completed a set of minimum prenatal guidelines that include required clinical elements, labs, education and referrals for non-complicated pregnancies. During 2013, work will address integration into the HFS maternity program and will require HFS decisions on how to operationalize and implement the guidelines.
- Promoting and facilitating the development of a statewide perinatal quality collaborative.

  CHIPRA convened a small group of stakeholders that met several times during 2012 to discuss the potential for a statewide perinatal quality collaborative. A strategic planning meeting with a broad stakeholder group was held in early December 2012. CHIPRA will continue to promote/facilitate this effort during 2013, with additional strategic planning

meetings planned for January and February and a kick-off meeting planned for Fall 2013. Perinatal collaboratives in other states have resulted in significant improved outcomes and savings. One of the biggest hurdles for this group will be initial and ongoing funding.

- Recommending protocols for perinatal care coordination.

  During 2012, a workgroup was convened to develop recommendations for perinatal care coordination and care transitions. This group will continue meeting in 2013 and will develop recommendations to present to HFS for endorsement and integration into HFS' maternity program.

- Developing a public education campaign on the benefits of preconception, prenatal and interconceptional care.

  Work on a public education strategy advanced during 2012. HFS partners with the Illinois Maternal and Child Health Coalition on this effort. Images and tag lines were developed to address key messages related to preconception, prenatal and interconception care. The images were reviewed by focus groups, with 193 individuals reviewing them in round one and 131 in round two. These groups provided input on the images and messages. The images and tag lines have been finalized and will be incorporated into an overall public education strategy that will include a provider tool kit, educational materials, and other CHIPRA work products, including the minimum standards, prenatal electronic data set, and perinatal care coordination guidelines.

Managed Care - External Quality Review Organization

As mandated by federal regulations (*42 CFR Part 438 Subpart E*), HFS contracts with an External Quality Review Organization (EQRO) to provide quality assurance oversight of the Managed Care Organizations (MCOs). As a result of a competitive procurement, HFS has contracted with Health Services Advisory Group (HSAG) that began June 1, 2006 and ended on December 31, 2012. HFS recently executed an EQRO contract through a new competitive process with HSAG for a three year term beginning January 1, 2013 and ending December 31, 2015, with three one-year options to renew thereafter. HSAG provides federally-required External Quality Review activities, as well as technical assistance, to the MCOs under contract with HFS. This includes two contracted MCOs for the Integrated Care Program, three contracted MCOs for the Voluntary Managed Care Program, and several new MCOs and care coordination entities through the Innovations program.

State Quality Assessment and Performance Improvement Strategy for Managed Care

As required by *42 CFR 438.200*, and with a goal to accomplish HFS' mission of empowering individuals enrolled in managed care programs to improve their health while containing costs and maintaining program integrity, HFS developed a written strategy for assessing and improving the quality of Medicaid MCOs. The MCO State Quality Strategy establishes a framework for ongoing assessment and identification of potential opportunities for health care coordination and improvement, ensuring the delivery of the highest quality and most cost-effective services possible. The Quality Strategy was developed with input from provider groups, advocates, MCOs and HFS and was reviewed by CMS. To align with the Affordable Care Act and the Illinois Medicaid reform law, the Quality Strategy was updated in 2012 to include the Integrated Care Program, Coordinated Care Innovations Project, Medicare-Medicaid Alignment Initiative and expand on performance goals, measurable targets and satisfactory progress toward those targets.

HFS has identified the following five goals for its Quality Strategy:

Goal 1: Ensure adequate access to care and services for Illinois Medicaid recipients that is appropriate, cost effective, safe and timely.

Goal 2: Ensure the quality of care and services delivered to Illinois Medicaid recipients.

Goal 3: Improve Care Coordination—the right care, right time, right setting, right provider.

Goal 4: Ensure consumer satisfaction with access to, and the quality of, care and services delivered by Illinois Medicaid Managed Care Programs.

Goal 5: Ensure efficient and effective administration of Illinois Medicaid Managed Care Programs.

As required by contract, the EQRO performs an annual External Quality Review using CMS protocols to assess the completeness of the MCO State Quality Strategy. 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 HFS, at the direction of HFS.

EQR Technical Report

HSAG provided HFS with the 2010-2011 EQR Technical Report describing the manner in which data from External Quality Review activities was aggregated and analyzed. The technical report focuses on 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. This and previous reports are available on the Department's Web site at:
http://www2.illinois.gov/hfs/ManagedCare/Pages/EQRTR.aspx

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. The Department contracts with eQHealth Solutions, a federally designated quality improvement organization, to assist in providing these services. eQHealth Solutions participates in quality studies and initiatives designed to identify issues of concern and improve quality of care and makes recommendations on implementation of strategies to improve outcomes. The utilization review services and quality assurance studies performed under this contract are eligible for an enhanced federal match rate of 75 percent.

During fiscal year 2012, non-certification of medically unnecessary services resulted in direct cost savings of $23.6 million for an estimated cumulative savings of $237 million since it began contracting with HFS as the Illinois Medicaid Quality Improvement Organization in 2002. The return on investment is estimated at $3.02 saved for every dollar invested. The following types of reviews are performed:

- Utilization Reviews
  - 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 reimbursement to 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.
- Quality Reviews

  In addition to evaluating the medical necessity of inpatient services, the quality of care rendered is evaluated to ensure that professionally recognized standards of care are met. When potential quality concerns are identified, the nurse reviewer refers the case to a physician reviewer. In fiscal year 2012, 818 retrospective reviews failed quality screens and

were referred to a physician reviewer. During fiscal year 2012, 15% of all physician referrals resulted in medical necessity denials. The overall denial rate remained steady compared with the prior fiscal year.

Review Activity

In fiscal year 2012, eQHealth conducted 220,417 concurrent and retrospective reviews associated with 121,422 hospitalizations. In addition, 18,448 child and adolescent psychiatric hospitalization reviews were performed. This represents 18% of the total volume of all hospitalizations concurrently reviewed.

Special Projects, Collaboration, and Report Activity

During fiscal year 2012, 16 special studies and ad hoc data analyses were conducted to assist HFS in making informed program decisions. In addition, eQHealth's involvement in 7 special projects and studies served to advance statewide healthcare initiatives during FY12. eQHealth's expertise continues to support and advocate HFS' medical program goals. Hospital personnel rely on their knowledge of the Medicaid program and insight into provider challenges. eQHealth's Provider outreach program is a combination of:

- Provider communications – ensuring providers are consistently updated on Medicaid policies and review procedures as well as developing and distributing job aids to help providers meet HFS program requirements.
- Education and Training – web system training, general education sessions, and on-site provider outreach.
- Quality Coaching – evaluating providers' care delivery to safeguard patient safety

LTAC

The Long Term Acute Care (LTAC) Hospital Quality Improvement Transfer Act of 2010 (P. A. 96-1130) presented a unique opportunity for HFS and eQHealth Solutions to collaborate on a new and original affiliation. The program's intent is to better utilize the specialized services available, enhance the continuity and coordination of care for the patients, and improve patients' health outcomes. Utilization and quality reviews are conducted on all Medicaid beneficiaries admitted to a long term acute care (LTAC) facility. LTAC facilities are paid a supplemental per diem rate for patients who meet the requirements of the Act. 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 a qualified LTAC facility. Nine facilities have been certified as LTAC hospitals since the implementation of the Act.

The Act mandates concurrent review for all fee for service Medicaid LTAC hospitalizations for admissions on or after October 1, 2010. During fiscal year 2012, there were 2,558 LTAC hospitalizations which account for 2 percent of the total hospitalizations reviewed by eQHealth during the fiscal year. A total of 9,590 LTAC reviews were conducted. Medical/Surgical reviews comprised 81 percent of the review volume while 19 percent of the review volume was attributed to psych admissions. LTAC hospitals' certified days totaled 61,955 with 610 days denied.

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.

In 2007, a second revised iteration of the quality review process was released. CMS standardized three key steps in the review cycle, clarified the site visit policy, and included a worksheet and checklist to improve consistency of reports across regional offices. Concurrently, CMS released the newest edition of the 1915(c) application, which further clarified the design of the state quality improvement strategies with a focus on performance measures, sampling, and the continuous quality improvement process (discovery, remediation, and system improvement). CMS also established a tracking system for the timeliness of internal processes associated with the quality review, in an effort to facilitate effective waiver renewals.

Throughout fiscal year 2012, 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.

eQHealth, in its sixth year of providing quality reviews for the HCBS waivers, continued to work with HFS to assure that contract expectations for quality oversight and special projects were met. During fiscal year 2012, eQHealth conducted 28 comprehensive provider reviews for five waivers and 400 individual record reviews for four waivers. 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).

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 $1.83 billion in Medicaid cost during fiscal years 2010, 2011 and 2012: $567 million in fiscal year 2010; $623.4 million in fiscal year 2011 and; $640.7 million in fiscal year 2012. 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 the Inspector General (OIG) monitors the program integrity of the Medical Assistance program and related waiver programs subject to Federal Financial Participation. OIG's mission is to prevent, detect and eliminate fraud, waste, abuse, misconduct and

mismanagement in programs administered by Healthcare and Family Services and the Department of Human Services. In addition, the OIG ensures that the Department conforms to the federal requirements necessary to receive federal matching funds.

The OIG uses a custom built predictive modeling system called the "Dynamic Network Analysis" system (DNA) (highlighted as a federal CMS "Best Practice") to systematically monitor the claims submitted to the Department and initiate corrective actions or administrative sanctions. The DNA also provides data aggregation and extensive profiles of providers and clients for monitoring and review. Referrals from many sources may initiate a thorough data review that can lead to numerous available administrative actions or referrals to law enforcement, including:

- Peer reviews of providers for quality of care: Such reviews can lead to letters of correction or termination from the program.
- Pre- and Post-Payment Audits: These actions may either be desk audits or field audits resulting in recoupment of overpayments, the entry of integrity agreements, termination from the program or referral to law enforcement.
- Recipient Restriction: Overutilization by recipients, usually of narcotic prescriptions but under the SMART Act open to all provider types, may allow the OIG to restrict or "lock-in" the recipient to certain providers to aid in the coordination of care related to the specific overutilization.
- Recipient Eligibility Investigations: These investigations determine whether identified recipients have manipulated the system through false acts or omissions to obtain services or payments for which they were not eligible. These investigations may result in the identification of overpayments, closure of the medical assistance case and prosecution by state and federal agencies.
- SNAP Fraud: These proceedings are initiated by the U.S. Department of Agriculture-Office of Inspector General's investigations of fraudulent retailers. SNAP recipients dealing with that retailer are sent to OIG to pursue disqualification. Disqualifications can be from 12 months to life-time bans depending on the infraction.
- Sanctions: The Office of Counsel to the Inspector General administers the administrative sanctions surrounding the program integrity system in Illinois. Providers who have been audited, peer reviewed, or identified as receiving overpayments or providing poor quality of care, may be sanctioned. These sanctions can range from simple recoupment of overpayments, the entry of corporate integrity agreements, settlement agreements, suspensions, payment suspensions and termination.

Fiscal Year 2012 Activity

In fiscal year 2012, the Department completed peer reviews on 124 providers and audited 265 providers. The Department also began a non-emergency transportation desk audit initiative, starting the process on over 1,000 different audits. The Department terminated 144 providers

and suspended two providers from participation in the Medical Assistance Program. There were four additional providers who voluntarily withdrew to avoid disciplinary action. There were 68 providers that were notified to initiate corrective actions measures to improve selected areas of their practice. Overpayments totaling $11.1 million were collected due to provider audits. Restitution accounted for a little over $312,000. In addition during fiscal year 2012, there were 441 new recipients restricted to a primary care physician and/or pharmacy.

Fiscal Year 2011 Activity

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.

Fiscal Year 2010 Activity

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.

XIX. ACRONYMS

AABD	Aid to the Aged, Blind and Disabled
ADRC	Aging and Disability Resource Center
AKAA	All Kids Application Agents
ARRA	American Reinvestment and Recovery Act
AVRS	Automated Voice Response System
BPRA	Bureau of Program and Reimbursement Analysis
BSFB	Bright Smiles from Birth
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
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
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
FFP	Federal Financial Participation
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
HCFA	Health Care Financing Administration (federal)
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
HMO	Health Maintenance Organization
HSAG	Health Services Advisory Group
ICAAP	Illinois Chapter of the American Academy of Pediatrics
ICF/DD	Intermediate Care Facility for Developmental Disabilities
ICP	Integrated Care Program
IEP	Individualized Education Plan
IHC	Illinois Health Connect
IHW	Illinois Healthy Women

JCAR	Joint Committee on Administrative Rules
MAC	Maximum Allowable Cost
MCCN	Managed Care Community Networks
MCO	Managed Care Organization
MDS	Minimum Data Set
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
OAAP	Outpatient Assistance Adjustment Payment
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDL	Preferred Drug List
PIAP	Pediatric Inpatient Adjustment Program
PIP	Provider Incentive Payment
POAP	Pediatric Outpatient Adjustment Program
PPS	Prospective Payment System
RHC	Rural Health Clinic
SASS	Screening, Assessment and Support Services
SCHIP	State Children's Health Insurance Plan
SLF	Supportive Living Facility
SMART Act	Save Medicaid Access and Resources Together - Public Act 97-0689
SNAP	Safety Net Adjustment Payment
SPD	Seniors and Persons with Disabilities
TAG	Technical Advisory Group
TPL	Third Party Liability
WAC	Wholesale Acquisition Cost

XX. 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 resources (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 2012, 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 residents 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, 2012, there were 813 active AKAA 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 2012, the approval rate of AKAA 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 ($2,555 per month for a family of four). Children covered under All Kids Assist have no copayments or premiums. FamilyCare Assist parents have copayments of $3 or less per medical service or prescription received.

All Kids Share provides a full range of health benefits to eligible children. To be eligible, children must have countable family income over 133 percent and at or below 150 percent of the FPL (between $2,556 and $2,881 a month for a family of four).

The FamilyCare Share program ended on July 1, 2012 pursuant to provisions under the SMART Act.

Children in All Kids Share have a $2.00 copayment for each medical service and prescription received, up to a maximum of $100 per family per year. There are no copayments for well-child visits and immunizations. Families with members who are American Indians or Alaska Natives do not pay premiums or copayments.

All Kids Premium Level 1 provides a full range of health benefits to eligible children. For children to be eligible, families must have countable income over 150 percent and at or below 200 percent of the FPL (between $2,882 and $3,842 a month for a family of four).

Children eligible for All Kids Premium Level 1 pay monthly premiums of $15 for one child, $25 for two children, $30 for three, $35 for four, and $40 for five or more. All Kids Premium Level 1 children have a $3 or $5 copayment for each medical service or prescription received, up to a maximum of $100 per family per year.

There are no copayments for well-child visits and immunizations. Families with children who are American Indians or Alaska Natives do not pay premiums or copayments.

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 $3,843 and 5,763). Monthly premiums are $40 for one child and $80 for two or more children. Copayments 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 Rebate provides children 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 children. To be eligible, children must have countable family income over 133 percent and at or below 200 percent of the FPL (between $2,556 and $3,842 a month for a family of four). To qualify, they must have health insurance that covers physician and inpatient hospital care. Copayments and premiums for All Kids Rebate children 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 $3,842 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 copayments or premiums and must live in Illinois.

Health Benefits for Persons with Breast or Cervical Cancer[1] (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 2012, 4,842 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 few months on December 3, 2010. For additional information, visit the Breast Cancer Quality Screening and Treatment Board's Web site

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

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 resources. Retirement accounts and medical savings accounts are exempt. Federal matching funds are available under Medicaid for these benefits.

During fiscal year 2012, HBWD provided health coverage to a monthly average of 846 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>

Illinois Cares Rx Program (formerly SeniorCare and Circuit Breaker Pharmaceutical Assistance)[1] ended on June 30, 2012 pursuant to provisions of the SMART Act.

Illinois Healthy Women (IHW) Program[1] 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, 2012 an unduplicated total of 151,960 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 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-1 (QI-1) programs. Resources are limited to $6,940 for a single person and $10,410 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 2012, 4,781 new individuals had enrolled in Pay-in Spendown Program, bringing total enrollment to 25,690, an increase of 4,781 individuals from fiscal year 2011. In fiscal year 2012 these individuals made $1,656,800 payments totaling approximately $4,880,900 toward their spenddown amounts. Additional information on the Pay-In program can be found at: www.hfs.illinois.gov/medicalbrochures/hfs591sp.html

State Hemophilia Program[1] 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 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 in the Chapter 100 Handbook on the Department's Web site.

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

State Chronic Renal Disease Program[1] 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 State Chronic Renal Disease Program

State Sexual Assault Survivors Emergency Treatment Program[1] 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 in the Chapter 100 Handbook on the Department's Web site.

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 2012, 897 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/

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] This program ended June 30, 2012 pursuant to provisions of the SMART Act.

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. Under the current waiver, parental income is waived (or not considered) when determining financial eligibility for Medicaid and cost-effectiveness for eligibility is 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. At the end of fiscal year 2012, the State submitted the request for renewal. The renewal is still under federal review, so the current waiver has been extended. The proposed changes submitted in the renewal cannot be implemented until federal approval is received.

During federal fiscal year 2012, 614 unduplicated children, were served under the waiver. Medical eligibility for the waiver is determined by an objective Level of Care screening tool, implemented in March of 2009. The primary expenditure under the MFTD waiver is for skilled nursing, which is available to children as a non-waiver service under the State Plan. Services available only under the current waiver include respite, environmental modifications, nurse training, family training, placement maintenance counseling, and special medical equipment and supplies.

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.

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. During federal fiscal year 2012, 17,585 individuals received services under the waiver.

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.

In fiscal year 2012, HFS and DHS worked to improve quality reporting for the waiver renewal effective at the beginning of fiscal year 2013. Improvements included: increased capacity due to the Ligas Consent Decree, implementation of a new quality improvement system with new waiver performance measures, an action plan for critical incident reporting, and the merging of assistive technology and adaptive equipment.

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. When this waiver was approved 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. Later in that year, an amendment was approved to increase the waiver capacity from 1,300 to 1,400.

In federal fiscal year 2012, 1,369 persons were served in the waiver. 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.

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. 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 2012, an amendment was granted to increase waiver capacity from 258 to 280 in order to accommodate the 269 persons that were served. 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.

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. During federal fiscal year 2012, 4,733 persons were served.

In fiscal year 2012, HFS and DHS prepared the waiver for renewal effective on 7/1/2012. Eligibility criteria were modified to more clearly define the waiver population and to assure that the waiver participant's functional deficits were related directly to their brain injury. A second component assured that persons in the waiver required the specialized brain injury services and specialized case management. For those that didn't meet the criteria, but still required in-home waiver services, a transition process was designed. The transition process moved these individuals to the persons with disabilities waiver. Other modifications to the waiver included an enhanced quality improvement system, new performance measures, and an action plan for critical incident reporting.

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. During federal fiscal year 2012, there were 1,392 persons served.

The waiver is operated by the DHS-DRS Home Services Program and was initially approved in October 1990. In fiscal year 2012, CMS requested the State to submit an evidentiary report demonstrating compliance with the waiver assurances. On 4/27/12 CMS's response to the evidentiary report informed the State of non-compliance with federal assurances due to issues primarily related to inadequate sampling methodology for monitoring and inadequate performance measures. The State is working under an Action Plan to comply with federal requirements, prior to the renewal. Sampling methodology and performance measures will be modeled after the Brain Injury Waiver.

Persons with 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. The waiver served 21,448 individuals during fiscal year 2012. Under the waiver, special services are provided that allow 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.

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 elderly waiver served 38,638 seniors during federal fiscal year 2012.

The waiver was initially approved October 1, 1983 and was renewed in fiscal year 2010 effective October 1, 2009 through September 30, 2014. In fiscal year 2012, the waiver was amended to increase capacity for waiver years 2012-2014.

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 beginning July 1, 2007.

During fiscal year 2012, 8,841 Medicaid eligible residents participated in the program. At the end of fiscal year 2012, there were 136 SLFs, with a total of 10,867 apartments, in operation. This was a six percent increase in the number of SLFs and a seven percent increase in the number of apartments available from the previous year. There are 26 more facilities in various stages of development.

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.

Appendix C – Final Budget Actions Worksheet on SMART Act

FY13 Medical Assistance Budget Actions Associated with Senate Bill 2840 – As Passed by the General Assembly on May 24, 2012

Dollars in Thousands

Item #	Category	Item Name	Proposed Change	Gross Savings*
1	Eligibility	Family Care adults	Reduce eligibility to 133% FPL; eliminate coverage for grandfathered adults 185%-400%	$49,884.7
2	Eligibility	General Assistance adults	Eliminate state coverage for all clients	$16,681.3
3	Eligibility	Illinois Cares Rx	Terminate program	$72,154.0
4	Eligibility Verification	Enhanced eligibility verification/private vendor	Utilize vendor with access to national databases to verify financial eligibility	$350,000.0
5	Eligibility Verification	Long-term care asset testing	Tightened asset testing policy for seniors applying for nursing homes	$3,000.0
6	Optional Service	Adult dental	Eliminate services for adults except for emergency care	$35,428.2

Item #	Category	Item Name	Proposed Change	Gross Savings*
7	Optional Service	Adult chiropractic	Eliminate services	$884.5
8	Optional Service	Adult podiatry	Limit service to diabetics	$5,200.0
9	Optional Service	Adult eyeglasses	New policy: one pair every 2 years	$9,819.5
10	Optional Service	Group psychotherapy for NH residents (and related transportation)	Eliminate services	$14,256.1
11	Optional Service	Pediatric palliative care	Make law inoperative before it is implemented	$4,500.0
12	Optional Service	Adult speech, hearing and language therapy services	Set annual maximum of 20 services per year	$411.0
13	Optional Service	Adult occupational therapy services	Set annual maximum of 20 services per year	$596.7
14	Optional Service	Adult physical therapy services	Set annual maximum of 20 services per year	$2,544.9
15	Optional Service	Hospice	Adopt Medicare policy to not pay for other care services when an individual is in hospice	$3,000.0
16	Optional Service	Home health	Reduce services through utilization controls	$2,000.0
17	Optional Service	Durable medical equipment	Impose utilization controls on oxygen, diabetic supplies, nebulizers and other medical equipment	$30,017.5
18	Utilization Controls	Adult detox services in hospitals	Impose concurrent review and limit adult detox inpatient admissions to one every 60 days	$25,492.4
19	Utilization Controls	Baby deliveries	Only pay normal vaginal delivery rate for C-sections, unless medically necessary	$2,854.0

Item #	Category	Item Name	Proposed Change	Gross Savings*
20	Utilization Controls	Hospital readmissions	Establish performance-based payment system related to potentially preventable readmissions	$40,000.0
21	Utilization Controls	Hospital provider preventable conditions (never events)	Eliminate payment for the entire hospital stay if a provider preventable condition occurs during that period	$30,000.0
22	Utilization Controls	Bariatric (weight loss) surgery	Impose utilization controls	$3,000.0
23	Utilization Controls	Coronary artery by-pass grafts	Impose utilization controls	$2,600.0
24	Utilization Controls	Eligibility for nursing facilities - change minimum Determination of Need (DON) score from 29 to 37	Change DON from 29 to 37	$4,400.0
25	Utilization Controls	Eligibility for supportive living facilities (SLF) - change minimum Determination of Need (DON) score from 29 to 37	Change DON from 29 to 37	$3,300.0
26	Utilization Controls	Ambulance services	Change law requiring ambulance transportation between 24-hour medically monitored institutions (i.e. hospitals/nursing homes)	$1,500.0
27	Utilization Controls	Non-emergency transportation	Reduce utilization	$4,000.0

Item #	Category	Item Name	Proposed Change	Gross Savings*
28	Utilization Controls	Pharmaceuticals - prescriptions in Long Term Care settings	Require pharmacies to dispense brand name drugs in no more than seven days' supply for recipients in long term care settings	$150.0
29	Utilization Controls	Pharmaceuticals - monthly prescription limit	Require medical necessity reviews for prescriptions in excess of four per month for adults and children - can be increased based on prior authorization or other specialty drug/condition exception	$180,000.0
30	Utilization Controls	Pharmaceuticals - medication therapy management	Pilot project to test effectiveness	$500.0
31	Utilization Controls	Pharmaceuticals - cost avoidance	Reject claims where a patient has a third party payer that has not been billed first	$40,000.0
32	Utilization Controls	Pharmaceuticals - hemophilia protocols/clotting factor reimbursement	New protocols for treatment of hemophilia patients; new reimbursement methodology for clotting factor products	$11,995.3
33	Utilization Controls	Pharmaceuticals - AIDS medications	Implement new protocols for treatment of AIDS patients	$3,000.0
34	Utilization Controls	Pharmaceuticals - cancer/biologicals	Implement prior approval, utilization limits and pricing strategies on certain physician administered drugs	$5,000.0
35	Utilization Controls	Pharmaceuticals - transplants medications	Require prior approval for brand immunosuppressive products that have generic equivalents. Work with hospitals to initiate immunosuppressive drug therapy for transplant patients with generic drugs, rather than expensive, brand name drugs.	$2,700.0

Item #	Category	Item Name	Proposed Change	Gross Savings*
36	Utilization Controls	Wheelchair repairs	Require prior approval on wheelchair repairs	$800.0
37	Utilization Controls	Incontinence supplies	Quantity limit of 200 per month (from 300)	$5,000.0
38	Utilization Controls	Advanced imaging, cardiac imaging, pain management and back surgery	Reduce utilization	$13,600.0
39	Utilization Controls	Veterans' benefit enhancement	Move services to federal VA for qualifying veteran clients	$2,000.0
40	Cost Sharing	Co-pays	Implement full federally-allowable co-pays on services	$44,125.0
41	Cost Sharing	Children receiving home services such as in the Medically Fragile/Technology Dependent (MFTD) Medicaid Waiver	Changes to reflect cost-sharing based on parental income (500% of the federal poverty level) and new flexible rules for families, reducing utilization	$15,000.0
42	Rate Adjustment	Federally Qualified Health Centers/Managed Care	Eliminate need for HMO wrap-around payment	$13,200.0
43	Rate Adjustment	Long term acute hospital (LTAC) rates for ventilator-dependent patients	Adjust rates and prevent other hospitals from qualifying as an LTAC	$30,000.0
44	Rate Adjustment	Excellence in Academic Medicine	Eliminate	$13,800.0

Item #	Category	Item Name	Proposed Change	Gross Savings*
45	Rate Adjustment	Nursing Facility - nursing DD rate add-on	Eliminate $10 add-on for clients with a developmental disability (DD)	$472.0
46	Rate Adjustment	Nursing Home bed holds	Eliminate bed hold for adults age 21 and over in nursing homes	$8,305.0
47	Rate Adjustment	Supportive Living Facility rates	Delink rate increase from new nursing home tax funded nursing home rate increase effective for services rendered on or after May 1, 2011	$20,800.0
48	Rate Adjustment	Power wheelchair rates	Reimburse for power wheelchairs at actual purchase price rather than current practice of Medicare rate minus 6%	$1,900.0
49	Rate Adjustment	Pharmaceuticals	Limit reimbursement to qualifying providers receiving discounted drug prices from manufacturers under Section 340B of the Public Health Services Act to no more than their cost. Require providers eligible to participate in 340B to do so and pass savings to the State.	$15,000.0
50	Rate Adjustment	Sexual Assault Survivors Emergency Treatment Program rates	Reduce from reimbursing provider charges to Medicaid rates	$1,839.7
51	Care Coordination	Initiatives being launched in FY13 include: Integrated Care Program Phase II, Dual Eligibles Capitation Demonstration, Innovations Program - adults, Innovations Program - children	Focus on most expensive clients with complex health/behavioral health needs	$16,075.0

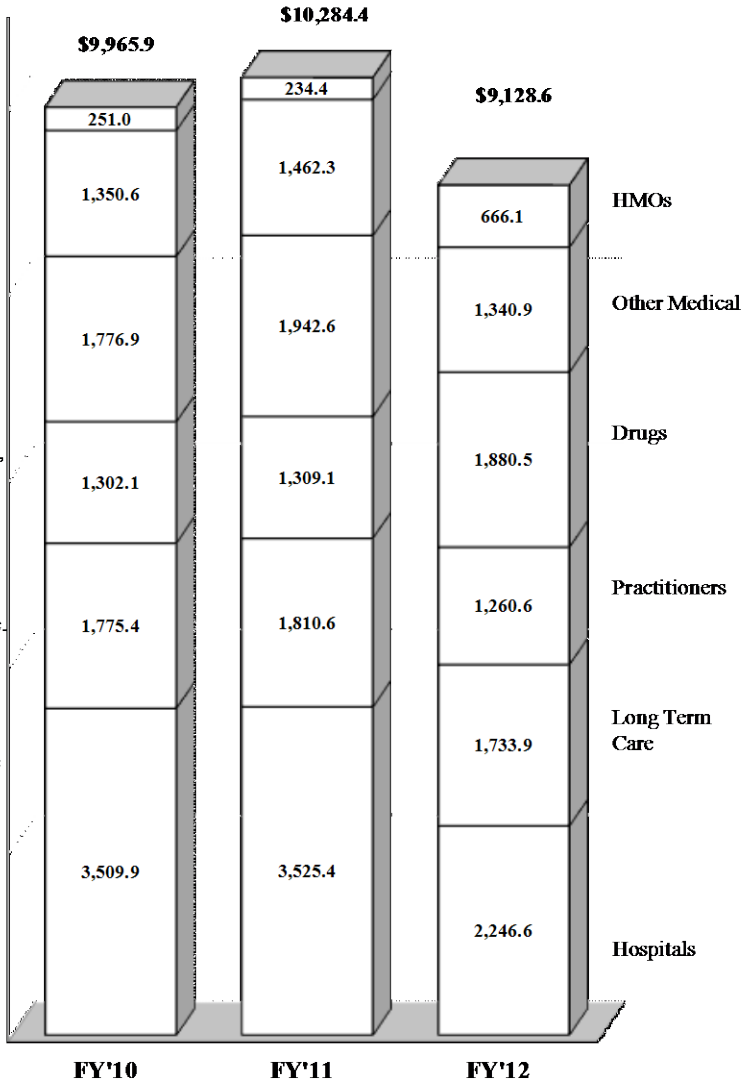
Item #	Category	Item Name	Proposed Change	Gross Savings*
52	Care Coordination	Chronic mental health care coordination	Expand care coordination to additional persons with chronic mental health conditions in nursing homes	$36,851.2
53	Care Coordination	Improving birth outcomes	Develop a statewide multi-agency initiative to improve birth outcomes and reduce costs associated with babies being born with low and very low birth weight and fetal death	$25,000.0
54	Other	Dental grants	Eliminate new state-only funded grants for FY13	$1,000.0
55	Other	Recipient Eligibility Verification vendors (revenue item)	Increase the number of vendors with connections to HFS systems and increase fees for transactions processed through those connections	$1,000.0
56	Other	Hospital outpatient drugs - rebates (revenue item)	Collect drug rebates on drugs provided in outpatient settings	$20,000.0
57	Other	Third party liability	Contract with vendor to enhance HFS' current collections efforts	$10,000.0
58	Other	Recovery audit contractor (RAC)/payment recapture audits	Implement RAC audits as a supplement to Inspector General's reviews	$21,875.0
59	Other	Pharmaceuticals	Savings related to a significant number of high cost name brand drugs going generic	$77,700.0
60	Other	Contracts no longer eligible for federal match	Eliminate	$3,000.0
61	Other	All Kids application agent payment	Allow contracts to expire after June 30, 2012 and allow AKAA's to continue in no-pay status	$850.0

Item #	Category	Item Name	Proposed Change	Gross Savings*
62	Rate Reduction	General medical provider rate reductions	Reduce most medical provider reimbursement rates by 2.7% effective July 1, 2012, with exceptions	$240,000.0
				$1,600,063.1
	Notes: *Savings figures reflect 12 month values and assume a July 1, 2012 date of service date unless otherwise noted. The figures will need to be modified for any changes to that date and for provider billing lags. Emergency rulemaking is also assumed.			

XXI. GRAPHS

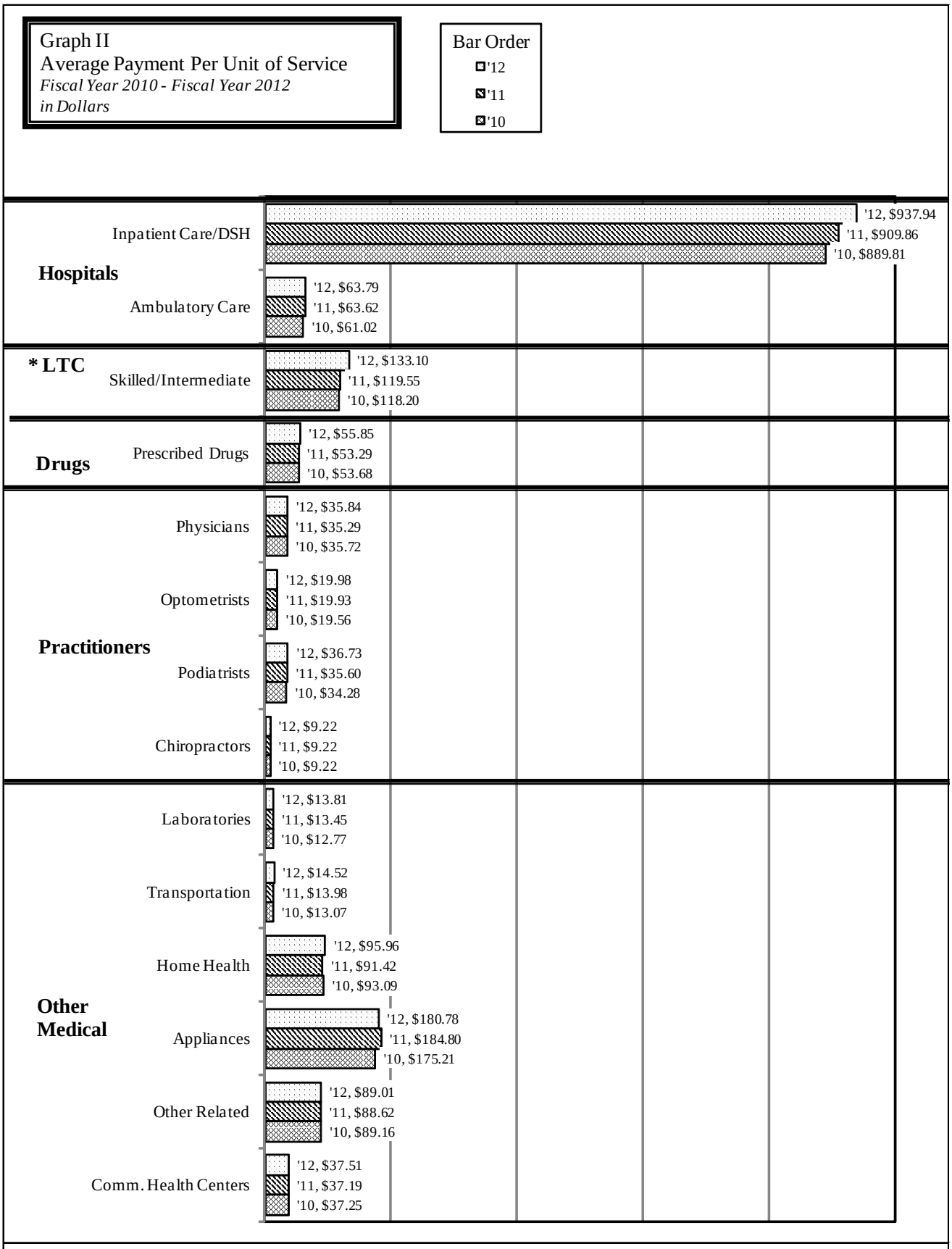
Graph I
Medical Programs Spending
Fiscal Year 2010-Fiscal Year 2012
Dollars in Millions

Fiscal Year	Events That Affected Spending
2010	Other Medical includes amounts paid via offsets to federal financial participation (FFP) draws.
2011	Other Medical includes amounts paid via offsets to FFP draws. Includes spending to buy-down unpaid bills at June 30, 2011, to maximize ARRA-enhanced federal match. Reflects the advance and payment of one-month's long-term care liability per PA 96-1405.
2012	Reflects 11 months of long term liability instead of 12 related to PA 96-1405 above. Reflects full year of Integrated Care Program in HMOs. General Assembly action resulted in $1.4 billion in unplanned and unfunded pressures to the FY12 Medical Assistance budget. These pressures will result in approximately $2.1 billion in unpaid bills being pushed into FY13 creating longer payment cycles. Other Medical includes amounts paid via offsets to FFP draws.



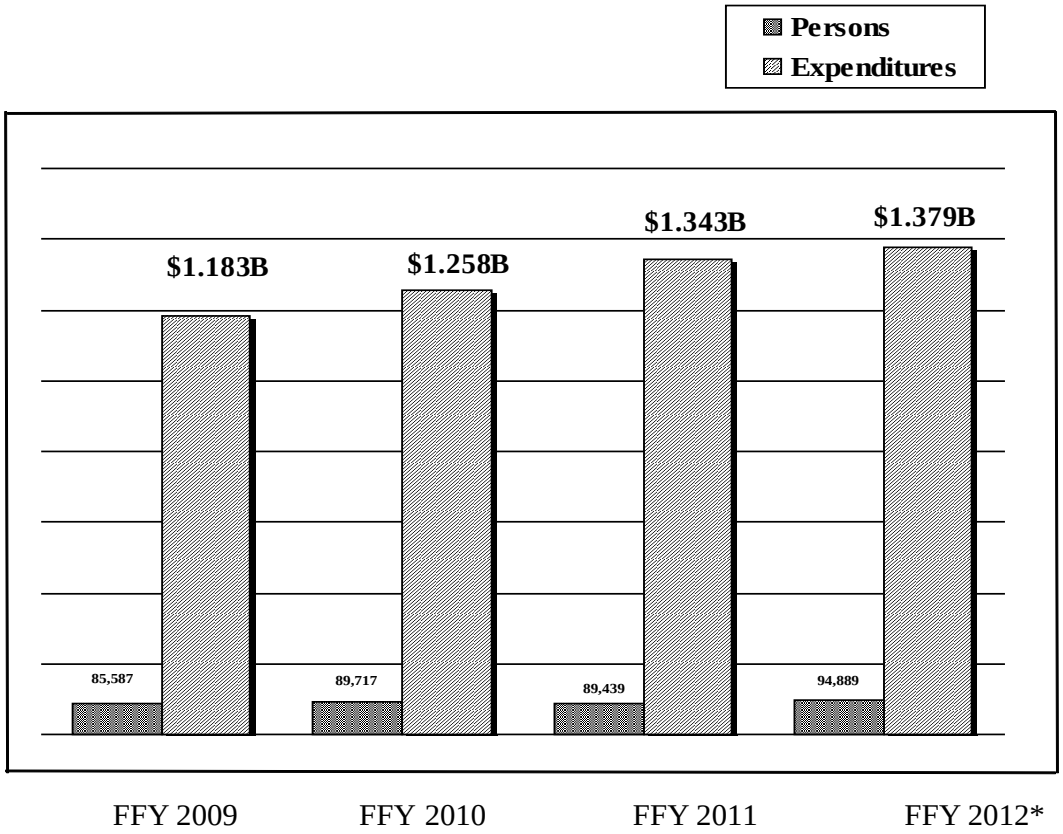
Note: Not included in total spending are expenditures from the (Cook) County Provider Trust, University of Illinois Hospital Services, Trauma Center, Non-entitlements, Hospital Provider (relating to the assessment), Medicaid Research and Development, Special Education Medicaid Match, Independent Academic 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'12, January 8, 2013.



An adjudicated unit of service is defined as a service processed through the MDW system and does not include services provided through pre-paid health plans (HMOs, PHPs, Doral Dental) or hospice. Average payment rate after adjustments for patient copayments, TPL, bed reserves, etc. For LTC, a unit of service is a day, while in physicians, it is a single procedure code. For hospitals, DCN date is being used as of FY12. Historical reflects change. *Long Term Care rate data reflects charge rate, which includes patient and third party contributions. SLFs are not included.

Graph III
Medicaid Waiver
Persons and Expenditures
Federal Fiscal Year 2009–
Federal Fiscal Year 2012



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 federal 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 that 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.

* FFY 2012 numbers are based on data available as of January 24, 2013.

XXII. TABLES

Table I
Licensed/Medicaid-Certified
Long Term Care Beds
Fiscal Year 2012 Actual

Level of Care	Medicaid Certified Beds [1]	Licensed Beds [2]
Skilled Care	66,972	77,120
Intermediate Care	16,382	18,167
Intermediate Care for the Mentally Retarded (ICF/MR)	5,969	5,969
Skilled Pediatric Care	932	932
Total	90,255	102,188

1 Reflects those beds that participate in the Medical Assistance Program and are available to Medicaid residents.
2 Reflects those beds that are licensed to operate under the Nursing Home Care Act, and hospital based LTC units.

Note: Sheltered Care beds are not certified for Medicaid.

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 2010 - Fiscal Year 2012

	Long Term Care - Total			Percent Change
	FY'10	FY'11	FY'12	FY'11 to FY'12
Total Charges [1] ($ Millions)	$2,320.51	$2,507.80	$2,192.54	-12.57%
Total HFS Liability [1] ($ Millions)	$1,792.26	$1,911.30	$1,851.84	-3.11%
Total Patient Days (Days in Millions)	20.06	21.59	18.50	-14.31%
Weighted Average Rate [2] Per Diem	$89.35	$88.53	$100.09	13.06%
Average Payment (Charge) Per Diem	$115.68	$116.17	$118.51	2.01%

1 Reflects date of service liability for nursing facilities and supportive living facilities.
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 2010 -Fiscal Year 2012
Dollars in Thousands

	FY'10 Expenditures	Percent	FY'11 Expenditures	Percent	FY'12 Expenditures	Percent
Total	**$9,965,882.0**	**96.9%**	**$10,284,430.3**	**112.7%**	**$9,128,608.1**	**100.0%**
Hospitals [1]	**3,509,887.3**	**34.1%**	**3,525,388.6**	**38.6%**	**2,246,564.5**	**24.6%**
Inpatient	N/A		N/A		N/A	
Ambulatory Care	N/A		N/A		N/A	
Long Term Care [2]	**1,775,407.1**	**17.3%**	**1,810,618.9**	**19.8%**	**1,733,914.1**	**19.0%**
Practitioners	**1,302,094.1**	**12.7%**	**1,309,095.1**	**14.3%**	**1,260,642.4**	**13.8%**
Physicians	982,963.0	9.6%	986,389.5	10.8%	907,878.8	9.9%
Dentists	267,582.1	2.6%	266,748.9	2.9%	295,694.6	3.2%
Optometrists	42,707.9	0.4%	46,889.4	0.5%	47,450.5	0.5%
Podiatrists	7,327.8	0.1%	7,549.4	0.1%	8,217.8	0.1%
Chiropractors	1,513.3	0.0%	1,517.9	0.0%	1,400.7	0.0%
Drug	**1,776,864.6**	**17.3%**	**1,942,633.4**	**21.3%**	**1,880,529.9**	**20.6%**
Other Medical	**1,343,320.7**	**13.1%**	**1,456,351.0**	**16.0%**	**1,334,716.2**	**14.6%**
Laboratories	56,943.0	0.6%	59,372.2	0.7%	51,948.2	0.6%
Transportation	94,284.9	0.9%	85,946.0	0.9%	66,738.5	0.7%
SMIB/HIB/Expansion [3]	338,186.0	3.3%	390,931.5	4.3%	389,452.8	4.3%
Home Health Care/DSCC	155,581.6	1.5%	164,106.3	1.8%	151,829.1	1.7%
Appliances	90,468.8	0.9%	92,041.4	1.0%	80,517.4	0.9%
Other Related [4]	200,124.6	1.9%	201,935.1	2.2%	184,650.9	2.0%
Comm Health Centers	291,401.8	2.8%	336,901.9	3.7%	299,162.7	3.3%
Hospice Care	84,314.4	0.8%	89,315.7	1.0%	79,106.4	0.9%
Children's Mental Health Initiative	32,015.6	0.3%	35,800.9	0.4%	31,310.2	0.3%
HMOs	**250,979.9**	**2.4%**	**234,369.0**	**2.6%**	**666,072.9**	**7.3%**
Children's Rebate	**7,328.3**	**0.1%**	**5,974.3**	**0.1%**	**6,168.1**	**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'12, January 8, 2013.

Table IV
Medicaid Providers
By Type of Service
Fiscal Year 2009-
Fiscal Year 2012

Provider Type	FY'09		FY'10		FY'11		FY'12	
Hospitals								
Cost Reporting	261		259		258		260	
Therapists[1]	4,047		4,044		4,467		5,276	
Clinics[2]	670		712		714		799	
Long Term Care Facilities Total	1,158		1,156		1,161		1,160	
Nursing Facilities		743		738		734		732
ICF/MR		301		299		300		292
Supportive Living Facilities		114		119		127		136
Physicians	35,668		37,754		39,218		43,151	
Dentists[3]	4,090		4,633		5,267		6,009	
Optometrists	780		820		933		1,015	
Podiatrists	578		593		605		634	
Chiropractors	554		539		546		567	
Pharmacies	2,779		2,796		2,849		2,883	
Laboratories/Portable X-rays	405		446		474		525	
Transportation	1,613		1,592		1,719		2,036	
Home Health Agencies	333		335		359		454	
Managed Care Organizations[4]	3		3		3		5	
Hospice	108		107		108		116	
Durable Medical Equipment	1,416		1,391		1,478		1,591	
Community Health Agency	7		7		7		7	
Other Providers[5]	4,626		4,896		5,780		7,092	
Total Providers	**59,096**		**62,083**		**65,946**		**73,580**	

[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
Medical Assistance
Mandatory/Optional Services

FEDERALLY REQUIRED MEDICAL ASSISTANCE SERVICES PROVIDED IN FY 2012

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 2012

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 2010 to 2012

	FY10	FY11	FY12	% Change FY10-FY12	% of Total Claims FY12
Total Claims Received	88,825,209	90,878,827	97,379,486	9.6%	
Physicans	29,894,559	30,211,937	36,395,611	21.7%	37.4%
Laboratory	1,970,450	1,889,471	2,226,043	13.0%	2.3%
Transportation Services	2,187,190	1,910,150	2,173,410	-0.6%	2.2%
Medical Equip/Supply	1,998,970	2,063,634	2,200,533	10.1%	2.3%
Health Agency	90,304	96,147	74,750	-17.2%	0.1%
Medicare	8,171,732	7,241,365	10,012,804	22.5%	10.3%
Pharmacy	38,719,681	41,551,228	38,333,419	-1.0%	39.4%
Hospitals	4,933,405	5,079,105	5,214,796	5.7%	5.4%
Long Term Care	822,165	817,112	746,919	-9.2%	0.8%
All Other Categories	36,753	18,678	1,201	-96.7%	0.0%

During fiscal year 2012, 97.4 million medical claims were received and processed by the Department. This was an increase of 7.2 percent over the number of claims received in fiscal year 2011 and a 9.6 percent increase over claims received during fiscal year 2010. Of all the claims received in fiscal year 2012, approximately 92.7 million (95.2 percent) were received via electronic transfer, down slightly from 96.2 percent in fiscal year 2011.

Pharmacy claims accounted for the largest share (39 percent) of total claims received during fiscal year 2012, with physician claims (37 percent), Medicare (10 percent), hospitals (5 percent), and claims for medical equipment/supply and labs (2+ percent) rounding out the top five receipt categories. Between fiscal years 2010 and 2012, the fastest growing claims category was Medicare showing approximately a 23 percent increase, followed by physicians increasing by almost 22 percent and lab claims increasing by 13 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 2012, the PrePay Pricing Unit reviewed the reimbursement requests for 6.8 million services, a decrease of 6 percent over the number of services reviewed in fiscal year 2011 and 7 percent less than the number services reviewed in fiscal year 2010. As a result of the PrePay Pricing Unit's review and pricing of claims, approximately $127.0 million in saving was realized by the Department in fiscal year 2012.

Table VII
Home and Community Based-Services Waivers

FY2012 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 12 Cap** 700 **# Served** 614 **Expenditures** $ 2,160,772	• Respite care • Environmental modifications • Specialized medical equipment and supplies, • Medically supervised day care, • Placement maintenance counseling, • Nurse and family training	None	Renewal: On 06/05/12, the state submitted the request for renewal. The renewal included changes outlined as a result of the SMART Act (SB2840) as well as other changes including removing respite as a service and a $25,000 cap over 5 years for environmental modifications and special equipment and supplies.

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 12 Cap** 280 **Served** 269 **Expenditures** $ 20,891,099	• Adaptive equipment • Assistive technology • Behavioral services • Residential habilitation	N/A	Amendment submitted on 6/13/12 increasing waiver capacity from 258 to 280. The effective date is 07/01/11.

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
Begin Date 07/01/10 **End Date** 06/30/15 **FFY 12 Cap:** 1,400 **Served** 1,369 **Expenditures** $17,005,439	• Home and vehicle accessibility modifications • Adaptive equipment • Assistive technology • Behavioral services • Service facilitation • Personal support • Caregiver training and counseling	• Temporary Assistance	Amendment approved on 08/01/11 requesting an increase in the capacity from 1,300 to 1,400 .The effective date is 07/01/10.

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 **FFY 12 Cap** 1534 **Served** 1,392 **Expenditures** $17,096,011	• Homemaker, • Home health aide services, • Personal care, • Nursing, • Environmental access, • PERS, • Home delivered meals. • Adult day care • PT, OT, ST • Special equipment and supplies • Respite	None	On 09/30/11, HFS received a request from CMS requesting the State to submit an evidentiary report demonstrating compliance with the waiver assurances. On 4/27/12 the State received a response to the evidentiary report informing the state of non-compliance with federal assurances due to issues primarily related to sampling methodology for monitoring. The State is working under an Action Plan to comply with federal requirements, prior to the renewal.

Adults with Developmental Disabilities *Operating Agency:* Department of Human Services, Division of Developmental Disabilities *Target Population:* Developmental Disabilities, 18 yrs or older			
Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 07/01/83 **Renewal** 07/01/12-06/30/17 **FFY 12 Cap** 17,600 **Served** 17,585 **Expenditures** $523,246,295	• Case management • Adult day care • Residential habilitation • Home-based services • Day habilitation • Supported employment • Environmental modifications • Specialized medical equipment and supplies • Physical (PT), occupational (OT), and speech (ST) therapies • Behavioral services • Personal support • Nursing • Transportation • Caregiver training • Crisis services • Assistive technology • Training and counseling for unpaid caregivers	• Crisis services • Assistive technology • Training and counseling for unpaid caregivers	Renewal: • Implemented new quality improvement system with new waiver performance measures. • Implemented an action plan for critical incident reporting. • Increased program capacity for Ligas consent decree • Merged assistive technology has been merged under adaptive equipment.

Persons with Brain Injury *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
Begin Date 07/01/99 **Renewal** 07/01/07-06/30/12 FFY 12 **Cap** 8,126 **# Served** 4,733 **Expenditures** $ 82,311,441	• 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 (PERS) • PT, OT and ST • Behavioral/cognitive services • Home delivered meals. • Respite	None	Renewal: • The waiver renewal more clearly defines the eligibility criteria for the brain injury waiver by assuring that an individual's functional deficits are related directly to the brain injury. • It also discusses the transition of persons to the persons with disabilities waiver that are assessed to not require the specialized brain injury case management and brain injury specific services • Implemented new quality improvement system with new waiver performance measures. • Implemented an action plan for critical incident reporting.

Persons with Disabilities *Operating Agency:* Department of Human Services, Division of Rehabilitation Services *Target Population:* Disabilities (0-59). Over 60 years of age, 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** 10/01/09-09/30/14 **FFY 12 Cap** 33,489 **Served** 21,448 **Expenditures** $ 312,503,429	• Homemaker, • Home health aide, • Personal care, • Respite, • Adult day care, • Environmental access • Nursing, • PERS • Home delivered meals • PT, OT, ST • Special equipment and supplies • Respite	None	N/A
Elderly *Operating Agency:* Department on Aging *Target Population:* Over 60 years of age.			
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 12 Cap** 44,250 **Served** 38,638 **Expenditures** $265,986,754	• Homemaker, • Adult day services, • Personal Emergency Response System (PERS)	None	An amendment was requested 6/13/12 to increase the waiver capacity for years 3 through 5 as follows: Year 3 (10/01/11-09/30/12): 34,050 to 44,250 Year 4 (10/01/12-09/30/13): 35,072 to 48,675 Year 5 (10/01/13-09/30/14): 36,124 to 52,237 The amendment has been approved effective 10/01/2011.

Supportive Living Program *Operating Agency:* Department of Healthcare and Family Services *Target Population:* Frail elderly aged 65 years and older, or those 22 to 64 years of age with disabilities			
Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 07/01/99 **Renewal** 07/01/12-06/30/17 **FFY 12 Cap** 11,500 **Served** 8,841 **Expenditures** $ 138,065,528	• 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 • Emergency call system	None	N/A

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 connecting directly to the Medicaid or CHIP 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

As of June 30, 2012, the Health Benefits/All Kids and the Drug Prior Approval Hotlines had received and handled over 730,000 calls from clients and providers. The Health Benefits/All Kids hotline responded to almost 433,000 calls and the Drug Prior Approval/Refill Too Soon Hotline answered over 306,000 calls.

Back Cover

This report was prepared to meet the obligation of four 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) 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.

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