ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

Fiscal Years 2011, 2012 and 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 2013. 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/)*.

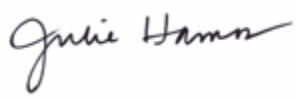
This report provides details on specific programs, participant numbers, and provider reimbursement. Information on HFS' Medical Assistance Programs is provided for the most recently completed fiscal year 2012 and the two previous years, to allow for comparisons for purposes of trending the services. Long term care-specific information is also contained for fiscal year 2013 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.

You will find specific information about the Department's progress toward the state law requirement to move at least 50% of Medicaid clients into care coordination by January 1, 2015. Clients residing in 5 mandatory managed care regions will select or be assigned to a managed care entity (MCE), and will have to stay with that MCE for one year (with exception of SPD Dual-eligibles). There will be a choice of at least 2 MCEs for each client. The other clients will remain in fee-for-service arrangements through Illinois Health Connect/Primary Care Case Management, until new MCEs develop in those regions. "Care coordination" will be provided by four types of MCEs in Illinois: Managed Care Organizations (MCO), which are traditional insurance-based companies accepting full-risk capitated payments; Managed Care Community Networks (MCCN), which are provider-organized entities accepting full-risk capitated payments; Care Coordination Entities (CCE) which are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis; and Accountable Care Entities (ACE), which are provider-organized entities on a 3-year path to full-risk capitated payments.

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,



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I. OVERVIEW

The Department of Healthcare and Family Services (HFS), Division of Medical Programs, administers and, in conjunction with the federal government, funds medical services provided to about 20 percent of the State's population. In fiscal year 2012, Medicaid, and the medical programs associated with it, provided comprehensive health care coverage to approximately 2.9 million Illinoisans and partial benefits to 86,087 individuals.

On average, each month the Department's programs cover approximately 2.9 million enrollees, including 1.7 million children, 181,000 seniors, 266,000 persons with disabilities, 713,000 non-disabled, non-senior adults and 86,000 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. There has been a large drop in partial benefits due to members of Illinois Cares RX program loosing eligibility due to the SMART ACT.

Comprehensive Benefits	**FY2011**	**FY2012**	**FY2013**
Children	1,677,575	1,697,175	1,647,423
Disabled Adults	260,228	266,664	266,419
Other Adults	636,531	647,451	713,402
Seniors	168,943	178,098	181,449
All Comprehensive	2,743,277	2,789,388	2,808,693
All Partial Benefits	309,387	269,336	86,087
Grand Total All Enrollees	**3,052,664**	**3,058,724**	**2,894,780**

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 2013, the Department spent approximately $15.1 billion (all funds), of which $11.6 billion was GRF/GRF like funds, on enrollee health benefits and related services. These individuals were served by approximately 69,600 providers of medical services, including 40,353 physicians, 2,829 pharmacies, 381 home health agencies, 236 hospitals and 721 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)*, continues to be the centerpiece of the Department's Medicaid reform efforts. As such, the transition from a fee-for-service system to a more integrated healthcare delivery system requires 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 continues to develop and implement its Care Coordination initiatives.

As the Department expands its care coordination efforts, most of the care individuals enrolled in the HFS Medical Programs in the mandatory regions receive will be provided primarily by one of four types of entities:

- Managed Care Organizations (MCOs), which are traditional insurance-based companies accepting full-risk capitated payments;
- Managed Care Community Networks (MCCN), which are provider-organized entities accepting partial-risk or full-risk capitated payments;
- Care Coordination Entities (CCE), which are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis (this includes Children with Complex Medical Needs); and
- Accountable Care Entities (ACE), which are provider-organized entities on a three-year path to full-risk capitated payments.

Programs that will be implemented during 2014 as part of these initiatives include the following:

January, 2014

◊ ACA Adults: Begin enrollment into the Primary Care Case Management program. At a later date in 2014 these adults will begin to transition to the mandatory managed care plans (July 1, 2014 or later) in order to be in alignment with the Illinois Medicaid reform law.

February, 2014

◊ Began enrollment of approximately 80,000 Seniors and Persons with Disabilities in the city of Chicago into the Integrated Care Program and into Care Coordination Entities (CCEs). This expansion offers most individuals a choice between seven MCOs and three CCEs.

◊ Began enrollment into the Medicare-Medicaid Alignment Initiative for approximately 136,000 individuals with dual-eligiblity(Medicare/Medicaid) under dual-capitation in Central Illinois and the Greater Chicago region. The first effective date for enrollment into the MMAI program, through voluntary choice enrollments is March 1, 2014. The first effective dates for passive enrollment into the MMAI program is anticipated to be June 1, 2014. Individuals in the Greater Chicago area have up to six MCOs to select from for their plan. Individuals in the Central Illinois region have up to two plans to select from for their plan.

◊ The Department announced ACE awards and is working with awardees to implement this new delivery system beginning July 2014.

July, 2014

◊ Begin care coordination for children with complex medical needs with three CCEs.

◊ Begin mandatory enrollment of the Family Health Population and the newly eligible ACA adults, approximately 1.7 million individuals, into a care coordination system in the mandatory regions. Individuals currently enrolled in the Illinois Health Connect program or with a Voluntary Managed Care Organization and newly eligible ACA adults will be required to enroll with an MCO or ACE for their health care. Due to the volume of individuals that will be

selecting a plan under this expansion, the enrollment choice periods will be implemented over a period of months.

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 January 1, 2014, there were 59,636 clients enrolled in the ICP.

The program first became operational in the pilot areas of suburban Cook (excluding the city of Chicago itself), DuPage, Kane, Kankakee, Lake and Will Counties. ICP was expanded to four additional regions in 2013:

- Rockford region (Winnebago, Boone and McHenry counties) was added in July,
- Central Illinois region (Knox, Stark, Peoria, Tazewell, McLean, Ford, Menard, Logan, Sangamon, Christian, Mason, Piatt, DeWitt, Champaign and Vermilion counties) went live in September,
- Metro East region, consisting of St. Clair, Clinton and Madison counties, also began in September, and
- Quad Cities region (Rock Island, Henry and Mercer counties) was added in November.

To achieve improvements in health, the ICP coordinates care between local primary care physicians, specialists, hospitals, nursing homes, behavioral health providers and other providers so that all care is organized around the needs of the client. The ICP was phased in as two service packages, and it began with the initial rollout of Service Package I for acute health services, such as physician, hospital and pharmacy. Service Package II covers Long-Term Services and Supports, including Home and Community Based waiver and nursing facility services, 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

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 provides alternatives to MCO models of delivering care, aligns with Affordable Care Act initiatives, incorporates feedback from stakeholders and builds on interagency collaborations.

The Department began this effort in early 2012, with the release of a solicitation seeking qualified and financially sound CCEs and MCCNs to enter into contracts to coordinate care for Seniors and Persons with Disabilities (SPDs) with a particular emphasis on managing transitions between levels of care and coordination between physical and mental health.

The solicitation fulfilled a goal to allow providers to design and offer care coordination models other than traditional Managed Care Organizations (MCOs). In October of 2012, the Department selected six proposals for awards to five CCEs and one MCCN based on their demonstrated ability to offer an innovative holistic approach to delivering coordinated care. Enrollment into the CCE program began in September 2013 and will continue into early 2014 for approximately 8,000 SPDs.

As recommended by the stakeholder group established under the Medicaid reform law, a second solicitation for CCEs to serve Children with Complex Medical Needs (CCMNs) was released in

December 2012. Under the solicitation, the State was seeking the services of one or more qualified, experienced and financially sound CCEs to serve Children with Complex Medical Needs under the Innovations Project. The CCMN CCEs will coordinate care for Children with Complex Medical Needs across the spectrum of the healthcare system with a particular emphasis on managing transitions between levels of care and coordination among hospitals, physicians and behavioral health providers. In addition, the CCEs 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. The Department received seven proposals in response to the solicitation. In September of 2013, the Department selected three proposals for awards. The Department is in contract negotiations with each of the three entities and anticipates enrolling individuals into the CCMN CCEs beginning July 2014.

C. Medicare-Medicaid Alignment Initiative

The health plans were selected based on their demonstrated ability to offer a holistic approach to delivering coordinated care for dual eligible clients. The Department received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement MMAI in early 2013, by reaching agreement and signing a Memorandum of Understanding that details the policies of the MMAI demonstration. Formal contracts were approved by HFS and CMS in the fall of 2013 with enrollments into the MMAI program beginning in early 2014 and enrollments becoming effective March 2014.

D. Accountable Care Entities

An Accountable Care Entity (ACE) is a new model of an integrated delivery system created under SB26, p0assed by the General Assembly in May 2013, and signed into law on July 22, 2013 (Public Act 98-104). This will be the fourth model providing “care coordination services” for Medicaid clients, and will have these elements: (1) will be organized by providers and will coordinate a network of Medicaid services; (2) will initially enroll children and their family members, with an option to enroll "newly eligible" adults under ACA; (3) will each be large enough to have impact for a population: at least 40,000 clients in Cook County, 20,000 in collar counties, 10,000 downstate; (4) will include at a minimum the following types of providers: primary care, specialty care, hospitals, and behavioral healthcare; (5) will have a governance structure that includes each type of provider; (6) will build an infrastructure to support care management functions among the providers in the network, such as health information technology, risk assessment tools, data analytics, and communication with Medicaid members; and (7) will be on a 3-year path to becoming a full risk bearing MCCN, with a new payment structure different from the current fee-for-service: shared savings within first 18 months, partial risk after 18 months, and full risk after 3 years.

In response to SB26, the Department issued a solicitation in August 2013 requesting proposals from newly formed ACEs by January 3, 2014, five months from the release of the Solicitation. The Department received 11 proposals. Conditional awards were made to 9 ACEs for start-up dates on or after July 1, 2014.

E. Medicaid Emergency Psychiatric Demonstration

One of eleven states chosen by Federal CMS to participate in the Medicaid Emergency Psychiatric Demonstration (MEPD) – Section 2707 of the Affordable Care Act – HFS, in collaboration with the Illinois Department of Human Services – Division of Mental Health (DHS–DMH), implemented Illinois’ Connect Program. As part of the demonstration, the Departments have partnered with Chicago Lakeshore Hospital, Riveredge Hospital, Presence Behavioral Health, and Community Counseling Centers of Chicago to established two Community Connect Networks in Cook County. Each Community Connect Network ensures that Medicaid eligible adults presenting at network participating Emergency Departments in psychiatric crisis can be routed to inpatient psychiatric care while avoiding unnecessary boarding and wait times at the Emergency Department. Each Community Connect Network has introduced Illness Management Recovery (IMR), a SAMHSA approved

evidence-based practice, as a treatment framework to increase consumer engagement and reduce psychiatric recidivism. The Federal MEPD Project is scheduled to sunset on June 30, 2015.

III. OTHER 2013 INITIATIVES

A. Screening, Assessment and Support Services Program

Since the passage 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 2013, the SASS program served in excess of 23,000 unique children and youth while the three Departments expended nearly $40 million in SASS funding for services and administrative costs.

B. 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 education programs and educational seminars on common child 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/

C. Psychotropic Medication Quality Improvement Project (PMQIC)

Healthcare and Family Services (HFS), in collaboration with the Illinois Department of Children and Family Services (DCFS), have partnered with the University Of Illinois School Of Psychiatry to implement the "Improving the Use of Psychotropic Medications among Children in Foster Care" initiative sponsored by the Center for Health Care Strategies (CHCS) and the Annie E. Casey Foundation. The PMQIC project is focused on: increasing the consent compliance on script writing for foster children; decreasing inappropriate requests for psychotropic medication small children; developing guidelines for second generation antipsychotics and maintenance pharmacotherapy; and other quality indicators for youth involved in the child welfare system. The work and systems impacts of Illinois' PMQIC project will be highlighted in a published study made available by CHCS upon completion of the three year initiative.

D. Hospital System Reimbursement Design

Throughout 2013, the Department continued to work with the hospital Technical Advisory Group (TAG), a group consisting of CEOs, CFOs and consultants representing numerous hospitals and hospital systems from across the state to assist in redesigning the hospital reimbursement system. Since

2011, there have been twenty-five 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. The Department and the TAG made great strides in developing new inpatient and outpatient reimbursement systems that recognize acuity, enhance payment for high cost acute care services and high volume providers, shift funding from the inpatient setting to outpatient, and create a transition period that provides system-wide stability by limiting impacts while hospitals become accustomed to the changes. The Department filed rules in February 2014, for a July 1, 2014 implementation date of both systems.

E. SMART Act

The SMART Act was passed in the 2012 legislative session to address an initial $2.7 billion Medicaid funding shortfall for Fiscal Year 2013. SMART Act assumed $1.6 billion of savings through 62 program reductions, including: eligibility reductions, optional services reductions, utilization control efforts, client cost sharing, and provider rate reductions. The remaining $1.1 billion funding shortfall was to be addressed by new program revenue.

The Department implemented the SMART Act to the best of its ability – achieving over $1 billion in directly attributable savings – and remained within the FY2013 budget due to the SMART Act, lower than estimated medical liability trends and less client enrollment.

The final outcome of the 2013 Smart Act 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.

F. Money Follows the Person and Long-Term Care Rebalancing

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 Coordinators who assist 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 2013.

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 2013, the MFP Program completed a total of 329 successful transitions, an increase of 37 transitions over the calendar year 2012 total. The MFP Program completed 1,104 cumulative transitions by the end of calendar year 2013. The Department anticipates growth in the number of transitions for calendar year 2014 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;
- Continued implementation of the Integrated Care Program/Phase 1 and 2 in suburban Cook Counties.

Calendar Year 2013 MFP Transitions

Population Group	# Transitions
Individuals who are Elderly	64
Individuals with a Physical Disability	81
Individuals with a Serious Mental Illness	37
Individuals with an Intellectual Disability	34
Colbert Class Members (cross population)	113
Total	329

*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	$3,705,114,411	$1,124,309,257	30,34%
2010	$3,914,893,414	$1,464,254,044	37.40%
2011	$4,795,106,902	$1,863,593,405	38.86%
2012	$4,047,494,360	$1,870,323,894	46.21%
2013	$4,697,974,907	1,937,032,337	41.23%

*Expenditures are reported using the CMS-64 quarterly claim totals as submitted to Federal CMS. Fiscal year totals include adjustments made for services in previous years.

Balancing Incentive Program

The federal Balancing Incentive Program (BIP), authorized by the Affordable Care Act, incentivizes transformation of state long-term care systems by encouraging states to shift from institutional to community-based long-term services and supports (LTSS). The purpose of the program is to improve access to non-institutional LTSS and encourage states to make structural reforms to their long-term care systems. A total of $3 billion has been made available for distribution to states from October 1, 2012 to September 30, 2015. States that spent less than 50 percent of their total Medicaid long-term care expenditures on non-institutional LTSS during 2009 qualify to receive an enhanced Federal Medical Assistance Percentage (FMAP). The Department of Healthcare & Family Services submitted an application to the federal Centers for Medicare & Medicaid Services (CMS) to participate in the BIP last Spring. The BIP application and subsequent BIP Work Plan were approved by CMS and Illinois began drawing down an enhanced FMAP of 2% on all of its community-based LTSS expenditures on July 1, 2013. Illinois anticipates receiving $90.3 M over the course of the BIP – through September 30, 2015.

To qualify for this additional funding, a state must:

- Show, by the end of the program in 2015, that it spends more than 50 percent of expenditures for LTSS on non-institutional services.
- Make structural reforms in long-term care systems including:
  - No wrong door/Coordinated Entry Point;
  - Conflict-free case management services; and
  - Uniform assessment process

The implementation of the BIP is a coordinated effort amongst HFS, the Department of Human Services, the Department on Aging, the Administration, the Illinois Framework, and a large and diverse group of stakeholders.

G. New Eligibility System

In another critical area, HFS has been deeply involved with the Department of Human Services (DHS) 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, should Illinois establishes its own Health Insurance Marketplace under the Affordable Care Act (ACA), the IES will be used to determine eligibility for participation in subsidies under the Marketplace. 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 federal government adopted to accelerate the development of systems to facilitate ACA implementation. The federal government offers a 90 percent match on the costs due to Medicaid and a 100 percent match on the costs due to the Exchange. 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. This group collaboratively sought federal money for a needs assessment and then a strategic planning effort, before competitively selecting Deloitte Consulting to develop and implement the IES.

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 was done at the Deloitte government services hub where they are involved with eligibility systems from several other states, and then moved to the State Data Center in the spring of 2013.

Basic strategy for development was around two fundamental phases:

- Phase one: Creating new front end for on-line applications that sent information to the legacy system which provided case maintenance until the IES was complete.
- Phase two: Replacing the back end legacy system completely and moving case maintenance function into IES.

Time frame was to complete Phase One by October 1, 2013 and Phase 2 in summer of 2015.

The IES includes increased automation of verifications of client information. These same verifications are being included in the redetermination process through some modifications to legacy system, although in a less automated way. These include matches to:

- Social Security for citizenship
- Social Security Administration for death match
- Illinois Secretary of State and United States Post Office for residency
- Social Security Administration for Social Security Benefits
- Illinois Department of Employment Security (IDES) for unemployment benefits
- IDES and The Work Number (a proprietary external employment data base) for wage income
  Transformed – Medicaid Statistical Information System (T-MSIS)
- Federal CMMS and specifically the Medicaid and CHIP Business Information Solutions MACBIS) group plans to receive Medicaid and CHIP data on a monthly basis in a standardized format from states in order to conduct program oversight and administration, and program integrity-related functions. The data and processes surrounding its collection are called the Transformed – Medicaid Statistical Information System (T-MSIS). CMMS and the State of Illinois seek to improve methods and processes to reduce the administrative burden of providing the data feeds, and to enhance and synchronize federal and state analytical capabilities. This project will create a new system that replaces Illinois' legacy MSIS.
- In developing a new T-MSIS data collection system in collaboration with CMS, and with Federal financial participation, the State of Illinois (Illinois) will efficiently and effectively plan, design, develop and implement (DDI) the system proposed and required by CMS. The new system will vastly expand the number and nature of informational items, thus enabling improved quality control and informed decision making for all healthcare stakeholders.
- This project is a joint effort with the federal government, the HFS Division of Medical Programs and the Division of Information Services. An Expedited Advanced Planning was approved for the project in the Spring of 2013. It secured enhanced federal funding at the ninety percent level of federal participation for the DDI phases. The estimate for the development is $2 million. The maintenance and operation will be matched at seventy-five percent.
- Illinois plans a comprehensive highly automated data extraction and reporting process, benefiting the many stakeholders by providing both accurate and reliable data. Effort from all states is necessary for CMS' vision for the redesign of the MSIS data warehouse and data reporting structure to be implemented nationally for all Medicaid programs in 2014.

IV. LONG TERM CARE

The monthly average of people served in nursing facilities (NFs) during fiscal year 2013 was approximately 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 2011 through 2013. 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 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 2013, four nursing facilities (NFs) and nine Intermediate Care Facilities for Individual s with Intellectual Disabilities (ICF/IIDs) closed. Of these facilities, one NF and two ICD/IID s were terminated from participating in the Medicare and Medicaid Programs due to non-compliance with federal requirements and all residents were relocated to appropriate settings. The remaining ten facilities (three NFs and seven ICF/IIDs) closed voluntarily. The seven ICF/IIDs closed to become Community Integrated Living Arrangements (CILAs). Four new NFs were enrolled in the Medical Assistance Program during this same period.

Nursing Facility Rate and Reimbursement System Redesign 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 (MOS 3.0) was implemented which contained new assessment information and was based on a new layout. The new system is web based and records are loaded to our EDW as they are received from a Federal feed. The MDS Data Repository system currently stores 3,486,779 assessments for 389,705 residents. For calendar year 2013, the system received and processed 1,084,813 new records, including admissions, quarterly updates, change of status, and discharge records for 192,975 unique individuals.

V. 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 continually reviews the waivers and requires each waiver to prove cost-neutrality 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 2012, 95,273 persons were served in HCBS waivers. The growth history of the waiver program from 2007 through 2012 is shown in the chart below:

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 LAG	98,057	$1,426,249,437
WY 2012 Initial	95,273	$1,414,445,875

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 2013 was full of activity for HCBS waivers in Illinois. Two of the nine waivers were renewed: brain injury and adults with developmental disabilities (DD). During this period, the renewal for the medically fragile and technology dependent children waiver was under review by federal CMS. For additional information on the HCBS waivers, please refer to Section II, Appendix B and Section XXII, Table VII of this report.

VI. 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 nearly 55 percent of all Illinois births and almost 95 percent of all births to teens in Illinois. As legislatively mandated (PA 93-0536), biennially HFS, in collaboration with DHS and IDPH, report

on the status of initiatives undertaken to address perinatal health in Illinois. The most recent report is available at: http://www.illinoishealthywomen.com/providers/report.html and provides a wealth of information about prenatal initiatives and a detailed analysis of prenatal outcomes. Birth outcome data are summarized below:

- Based on uncertified Vital Records data (CY2010-CY2012), the LBW (≤2,500 grams) rate appears relatively stable for those covered by Medicaid and for the total Illinois population between calendar year (CY) 2010 and CY2012. (Enterprise Data Warehouse, 2013)

- Based on uncertified IDPH Vital Records data, the rate of Very Low Birth Weight (VLBW = <1,500 grams) births was relatively stable for those covered by both Medicaid and the total Illinois population between CY 2010 and CY2012. While VLBW births represent approximately one percent of all birth outcomes, they account for approximately 20 percent of total birth costs (prenatal care, delivery, postpartum, and infant's first year of life). (Enterprise Data Warehouse, 2013)

- Based on uncertified IDPH Vital Records data, total Illinois and Medicaid-covered deliveries among teens (less than 20 years of age) decreased. However, Medicaid continues to cover almost 95 percent of teen deliveries in Illinois.2012.

Annual Number and Percentage of Illinois Teen* Births Covered by Medicaid (Provisional Data)

Calendar Year	# HFS Teen Births	# Illinois Teen Births	% Teen Births Covered by HFS
2010	14,134	14,714	96.1%
2011	12,267	12,942	94.8%
2012	11,331	12,026	94.2%

*Less than 20 years of age
Source: HFS Enterprise Data Warehouse, 2013, Birth File Match. These data are provisional pending certification of CY2010-CY2012 Illinois Department of Public Health Vital Records. Covered Deliveries are those where the recipient had full benefits on date of delivery.

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.

- The percentage of HFS-eligible women receiving family planning services (birth control) within six months after delivery has remained slightly higher among women who experienced a normal birth compared to those with a poor birth outcome. .

- 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 is at 50 percent.

- The percentage of HFS covered women who received more than 81 percent of the recommended prenatal visits decreased from 82.7 percent in CY2010 to 80.7 percent in CY2012.
- Among women who received perinatal depression screening, approximately 33 percent received it only prenatally; approximately 30 percent received only postpartum screening; and less than 20 percent received both prenatal and postpartum depression screenings.

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 2014 Perinatal Report can be found in its entirety at:
http://www2.illinois.gov/hfs/MedicalProvider/MaternalandChildHealthPromotion/Pages/report.aspx

HFS initiatives focused on improving birth outcomes are described below.

Illinois Healthy Women (IHW) – Planned Pregnancies

Since April 2004, the IHW program, a federal demonstration waiver, has provided a limited package of family planning (birth control) and related reproductive healthcare benefits for low-income women in Illinois. New federal healthcare laws, also known as the Affordable Care Act (ACA) requires all individuals to have minimum essential healthcare coverage, which includes birth control services. Therefore, women enrolled in IHW will now have the opportunity to obtain comprehensive healthcare coverage through either Expanded Medicaid or the Health Insurance Marketplace. To ensure a seamless transition into affordable health care plans, IHW will continue to provide coverage through December 31, 2014 to allow a transitional year for IHW clients to obtain other healthcare coverage.

IHW 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 March 31, 2013, a total of 177,190 unduplicated women received services. Over the last year there has been an increase of 30,590 women. During waiver year 9 (April 2012-March 2013), the average cost for a woman receiving a year of family planning services was approximately $396, while the average cost for prenatal care, delivery, postpartum care and the first year of the child's life was approximately $12,300. Using federal CMS' averted births methodology, during the first nine years of the waiver, it is estimated that 42,891 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 $494 million for those nine years. In addition to cost savings, IHW experienced the following successes:

- During the first nine years of the waiver, IHW reached its target population. Approximately 51 percent of the women who applied for IHW were ages 19 through 24, and of these women, 75 percent had never been pregnant;
- About 86 percent of the women who enrolled in IHW utilized family planning services;
- The average fertility rate for IHW women is 1.9 percent while the average fertility rate of low-income women in Illinois (<200% FPL) is approximately 11.6 percent, and the total population is approximately 7.0 percent. , and;

- Based on the 2009 PRAMS data, unintended pregnancies continued to show a downward trend throughout the first six years of the waiver.

The IHW website is currently being updated to reflect changes to ACA, however, additional information about IHW can be found at: http://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.

During CY2013, HFS finalized an algorithm developed to cull through the Enterprise Data Warehouse (EDW) to identify women who are presumed to be currently pregnant and who had a previous high cost birth. The algorithm runs weekly and provides a data feed to DHS for their use to engage women in early, intensive prenatal care coordinated with the woman's medical home through the Better Birth Outcomes Program (BBOP).

DHS and HFS discussed evaluation of the BBOP program. The evaluation will use data from both agencies matched to Medicaid claims for high-risk women who received intensive prenatal care services. The evaluation will include process, outcome and cost measures.

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); Bright Futures as a Standard of Care; Promoting Health: . Each of these initiatives is discussed in more detail in this report.

Two public-private partnership initiatives concluded at the end of CY2013. The Enhancing Developmentally Oriented Primary Care (EDOPC) project ended after nine total years. Initiated in 2005 as a partnership of the Illinois Chapter of the American Academy of Pediatrics (ICAAP), the Advocate Health Care Healthy Steps for Children Program, and other partners, EDOPC was a multi-year project to improve the delivery and financing of preventive health and developmental services for children in Illinois. Also concluded is the Improving Quality in Obesity Care grant agreement with ICAAP. This grant focused on improving provider practice around obesity care for children and adolescents by clarifying and promoting the use of codes associated with body mass index (BMI) assessment, and by promoting quality improvement activities.

Measuring Progress and Quality of Children's Health Care

The Children's Health Insurance Program Reauthorization Act (CHIPRA) established an initial core set of children's health quality measures. The May 2013 update to the core measures set includes the addition of three measures (Human Papillomavirus Vaccine for Female Adolescents, Behavioral Health Risk Assessment [For Pregnant Women] and Medicaion Management for People with Asthma). Therefore, the total CHIPRA core set currently totals 26 measures. Three of these measures are proposed for retirement in 2014, but currently remain in the core set.

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 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 For FFY2013 CARTS reporting, Illinois reported 25 of the 26 measures. These include two of three measures newly added in the May 2013 specifications that were rapidly programmed for reporting by the deadline. The only measure not reported is Behavioral Health Risk Assessment (For Pregnant Women) that uses electronic health record data that HFS does not collect.

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
PPC	Timeliness of Prenatal Care	Reported
FPC	Frequency of Ongoing Prenatal Care	Reported

	Measure	Status
LBW	Live Births Weighing Less than 2,500 Grams	Reported using uncertified Vital Records data
CSEC	Cesarean Rate for Nulliparous Singleton Vertex	Reported using uncertified Vital Records data
CIS	Childhood Immunization Status	Reported
IMA	Adolescent Immunization Status	Reported
WCC	Body Mass Index Assessment for Children/Adolescents	Reported
DEV	Developmental Screening in the First Three Years of Life	Reported
CHL	Chlamydia Screening	Reported
W15	Well-Child Visits in the First 15 Months of Life	Reported
W34	Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Reported
AWC	Adolescent Well-Care Visits	Reported
PDENT	Percentage of Eligibles that Received Preventive Dental Services	Reported via CMS 416
CAP	Children/Adolescent Access of Primary Care Practitioners (PCP)	Reported
CWP	Appropriate Testing for Children with Pharyngitis	Reported – Retiring FFY2014
	Otitis Media with Effusion (OME) – Avoidance of Inappropriate Use of Systemic Antimicrobials	Retired by CMS
TDENT	Percentage of Eligibles that Received Dental Treatment	Reported via CMS 416
AMB	Ambulatory Care – Emergency Department Visits	Reported
CLABSI	Pediatric Central Line-Associated Blood Stream Infections	Reported by CDC
ASMER	Annual Percentage of Asthma Patients With One or More Asthma-Related Emergency Room Visit	Reported – Retiring FFY2014
ADD	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Reported
PA1C	Annual Pediatric Hemoglobin (HbA1c) Testing	Reported – Retiring FFY2014
FUH	Follow-Up After Hospitalization for Mental Illness	Reported
CPC	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0H, Child Version	Reported as complete – must submit summary data during April 2014
HPV	New Measure May 2013: Human Papillomavirus Vaccine for Female Adolescents	Reported
BHRA	Behavioral Health Risk Assessment (For Pregnant	Not reported – E-

	Measure	Status
	Women)	specified measure, data not available
MMA	Medication Management for People with Asthma	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	**CY2010**	**CY2011**	**CY2012**
15 mo. olds with 6 or more well child visits	70.8%	71.6%	71.7%
15 mo. olds with zero well child visits	2.6%	2.6%	2.9%

Source: HFS Enterprise Data Warehouse, 2013

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 Population Percentage with at Least One Well Child Visit					
Calendar Year	**3 Yrs.**	**4 Yrs.**	**5 Yrs.**	**6 Yrs.**	**Total**
2010	74.2%	74.7%	78.0%	58.0%	**71.5%**
2011	74.3%	74.5%	77.4%	57.5%	**71.1%**
2012	72.2%	72.1%	74.9%	56.1%	**68.9%**

Source: HFS Enterprise Data Warehouse, 2013

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 Population Percentage with at Least One ODS

Calendar Year	1 Yr.	2 Yrs.	3 Yrs.	Total
2010	44.9%	35.1%	25.0%	**38.8%**
2011	51.3%	44.6%	26.8%	**44.7%**
2012	65.2%	49.0%	40.9%	**48.9%**

Source: HFS Enterprise Data Warehouse, 2013

Childhood Immunizations Status. The Department calculates immunization status of children at 24 and 36 months of age. The annual percentage of 36 month olds with Combo 2 immunizations (DTap, IPV, MMR, HiB, Hep B, VZV) is reflected in the table below. Two years are reported rather than three since the report was revised to meet CHIPRA specifications.

Immunizations Status* at 36 Months of Age: Title 19 and Title 21 Continuously Enrolled Population Percentage Fully Immunized	
Calendar Year	**Percentage**
2011	70.4%
2012	72.1%

Source: HFS Enterprise Data Warehouse, 2013, Combo 2

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
2012	74.0%	1,638,340	75.1	1,734,673

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.

VII. 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. The SMART Act limited adult dental coverage to emergencies, which was defined as a situation deemed medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury that can be treated by extraction only. However, in fiscal year 2013,Public Act 98-0104 amended the Public Aid Code to further define dental emergencies to include: :

- Extractions and dentures necessary for a diabetic to receive proper nutrition
- Extractions and dentures necessary as the result of cancer treatment
- Dental services necessary for an individual in order for the individual to be cleared for a medical procedure, such as a transplant
- Dental services necessary for the health of a pregnant woman prior to the delivery of her baby

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 2013 HEDIS results. The Department's 2013 Annual Dental Visit HEDIS measurement shows that 59.1 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 54 percent in 2011 and 56 percent in 2012.

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 2011, 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. Over 3,000 providers have been trained, including residents under the supervision of a physician, primary care providers and other health professionals. The training is now web-based and can be found at www.brightsmilesfrombirth.org. 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 2012, over 20,000 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 2013, payments for dental care totaled over $230 million. DentaQuest reported that 902,272 individuals under the age of 21 received over 7 million dental services, for a total expenditure of approximately $226 million. For the same time period, 51,777 individuals ages 21 and over received over 200,000emergency dental services for a total expenditure of approximately $7 million. The cost savings from fiscal year 2012 to fiscal year 2013 are a direct result of limiting the adult dental benefit to emergency dental services only. These program limitations were contained in the SMART Act.

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>

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

VIII. CARE MANAGEMENT

Managed Care

In 2013 the Illinois Managed Care program was expanded to include the Innovations Program for Seniors and Persons with Disabilities (SPDs), in addition to traditional 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. In 2014, the Department will implement additional managed care models to test innovative care coordination

models, such as the Care Coordination Innovations Project for Children with Complex Medical Needs (CCMN CCE), the Medicare-Medicaid Alignment Initiative (MMAI), and Accountable Care Entities (ACEs).

.**Integrated Care Program (ICP)**

The Department implemented the Integrated Care Program (ICP) in 2011 to improve the health care and quality of life for Illinois' Seniors and Persons with Disabilities (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 Department awarded contracts to Aetna Better Health and IlliniCare Health Plan in September of 2010 to integrate and manage the care of the nearly 35,000 SPDs who live in suburban Cook, DuPage, Kane, Kankakee, Lake and Will Counties and are enrolled in the ICP. ICP was expanded to four additional regions in 2013. Aetna Better Health, IlliniCare and Community Care Alliance of Illinois operate in the Rockford region (Winnebago, Boone and McHenry counties) which was added in July. The Department contracted with Molina, Meridian and Health Alliance to cover the Central Illinois region (Knox, Stark, Peoria, Tazewell, McLean, Ford, Menard, Logan, Sangamon, Christian, Mason, Piatt, DeWitt, Champaign and Vermilion counties) which began in September. The Metro East region, consisting of St. Clair, Clinton and Madison counties, also went live in September and is covered by Molina and Meridian. Lastly, IlliniCare operates in the Quad Cities region (Rock Island, Mercer and Henry counties) which was added in November. The savings/cost avoidance estimates over the initial five-year contracts with Aetna Better Health and IlliniCare were 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 2013, HFS spent $376.3 million in capitation payments to the ICP 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. Service Package II covers services needed by persons with disabilities that support their needs 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.

Assessment of Needs

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 assessed and 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 and receive high touch services from their care coordinators. 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– Illinois Health Connect

The Primary Care Case Management (PCCM) program was implemented in 2007 and serves most children and their families in the Medicaid and All Kids program. The PCCM program was the Department's first step toward implementing managed care throughout the state. As Illinois expands managed care in 2014, eligible clients in many counties will have a choice of at least two managed care entities from which to receive care coordination services. Expanding managed care also means that Illinois will be transitioning from a fee-for-service system, with few restrictions on where or how to deliver or receive services, to a system where it will be expected that providers will work in a collaborative fashion to offer integrated healthcare services focused around the holistic needs of clients. This will require a change in operations for Medicaid clients, for Medicaid providers, and for state agencies which will have to break down the silos of government. This will and also result in a reduction in the counties PCCM will operate. 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. As the new managed care programs are implemented, the Department will continue to support the PCCM program to ensure continuity of care for all enrollees.

As of June 30, 2013, 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 1.7 million enrollees were enrolled with a PCP in Illinois Health Connect for their medical home. In addition, as of June 30, 2013, IHC had enrolled 5,634 medical homes, which includes Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) enrolled sites. The enrolled medical homes provide a panel capacity of over 5.3 million patients, greatly exceeding capacity required for all eligible clients statewide. In most counties throughout Illinois, the medical home capacity for eligible clients is double the number of eligible clients in the country. This expansive network allows clients to have several choices of a medical home in most counties.

In 2013, the IHC program was 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 or CCE plans. 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.

Illinois Health Connect has implemented many outreach and education strategies to help client's better understand the importance of working with their PCP, how to access care, and the importance of health and wellness. An example of an Illinois Health Connect education strategy is the IHC Early Periodic Screening Diagnosis and Treatment (EPSDT) initiative. This initiative focuses on educating clients on the importance of EPSDT, encouraging clients to get well child checkups for their children, and assisting clients in making appointments with their child's PCP for needed primary and preventive checkups and services, such as immunizations. During FY13, the EPSDT outreach initiatives resulted in over 1.2 million Healthy Kids and over 70,000 Adult Preventive Notices mailed. In addition, Illinois Health Connect made almost 750,000 outreach and education calls to remind clients that primary and preventive services may be due based on HFS claims data; and to assist the client in making an appointment with their PCP to receive the needed services. Through these initiatives clients have access to care, are connecting with their medical homes, and are receiving the needed medical services in the most appropriate setting, their PCP's office.

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 continue to work 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 provides the following quality tools to PCPs for use in coordinating and providing care for their enrollees:

- *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* – Through the Department's secure MEDI system, 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. With the claims history of a client, the provider can see a client's medical history, assist in assessing additional medical needs and determine compliance.
- *Provider Profiles* – IHC PCPs, on a semi-annual basis (spring and fall), receive a profile report summarizing their individual performance on specified clinical indicators in addition to an

aggregate summary of the performance of all PCPs participating in the Illinois Health Connect program. The data reflected in the Provider Profiles is gathered from HFS claims data. Providers can obtain information regarding individual clients and whether they have received many of the clinical services reflected on the Provider Profiles by checking their Illinois Health Connect Panel Roster.

- *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.
- During FY13, Illinois Health Connects' Provider Service Representatives and Quality Assurance Nurses in the field made over 300 visits to providers' offices each month to assist with billing/coding questions, program administration, EPSDT standards, quality improvements efforts and to provide MEDI training.

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. During FY13, PCPs entered an average of 662 referrals per month. 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 12 percent during fiscal year 2013, from 215,687 participants at the beginning of the fiscal year (July 1, 2012) to 241,588 at the end of the fiscal year (June 30, 2013).

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.

Innovations Project - Care Coordination Entities for Seniors and Persons with Disabilities (CCE)

In 2013 the Department selected five CCEs based on their demonstrated ability to offer a holistic approach to delivering coordinated care for special populations, including seniors and adults with disabilities. It is anticipated that each entity will serve up to 1,500 Medicaid clients in the first year, as they establish and test their care coordination models before expanding, in the following years. The first of the five SPD CCEs was implemented in September 2013 with the other four CCEs being implemented from October 2013 through February 2014.

The Department recognizes that these CCE entities will need time to build their infrastructure, including the use of electronic health records, to be able to serve the eligible enrollees as envisioned under each care coordination model. The initial awards are anticipated to extend for a three-year term, with possible extensions based on specific quality and savings measurements assessed under each model during the initial term. Care coordination fees will be paid based on performance, but the plan must be at least cost neutral over three years through reduced use of emergency rooms, reduced hospital admissions and readmissions, follow-up care and other strategies. HFS will collect detailed data from each model and the data will be will be used to measure and assess the performance of the various models of care coordination.

Additional Care Coordination Initiatives Underway in 2014

2014 will see an increased roll-out of care coordination for most of the Medicaid populations. Specific planning was underway in 2013 with respect to:

- Care Coordination Innovations Project for Children with Complex Medical Needs
- Accountable Care Entities
- Medicare-Medicaid Alignment Initiative
- Managed Care Expansion beginning in July 2014 for Family Health Populations and ACA Adults

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.

IX. 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.

Provider assessments by provider class and year of assessment, fiscal years 1992-2013, in millions of dollars				
	Provider assessments			
Fiscal year	Total	Hospitals	Nursing facilities	ICFs/MR
Total	$ 11,108.80	$ 9,023.20	$ 1,661.70	$ 423.90
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
2013	1,413.3	1,196.2	196.6	20.5
Source:	Bureau of Hospital and Provider Services			

Since inception, these programs have generated over $22 billion in additional funding for the Medical Assistance Program ($11 billion in provider assessments and $11 billion in FFP).

During fiscal year 2013, hospitals, nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs/MR) continued to be assessed.

In fiscal year 2013 a new hospital outpatient assessment was enacted. The new assessment generated $306.0 million in assessments.

X. 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.

Affordable Care Act - Increased Payment for Primary Care Services
In January 2013, the Department implemented section 1202 of the Health Care and Education Reconciliation Act of 2010, which provides increased payments at the Medicare rate for certain Medicaid primary care services provided by certain qualified primary care providers. The increased rate applies to services provided January 1, 2013 through December 31, 2014, and the Department receives 100% federal match for the enhanced payments. The increased payments apply to services reimbursed by Medicaid (Title XIX) whether provided fee-for-service or through a managed care plan.

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

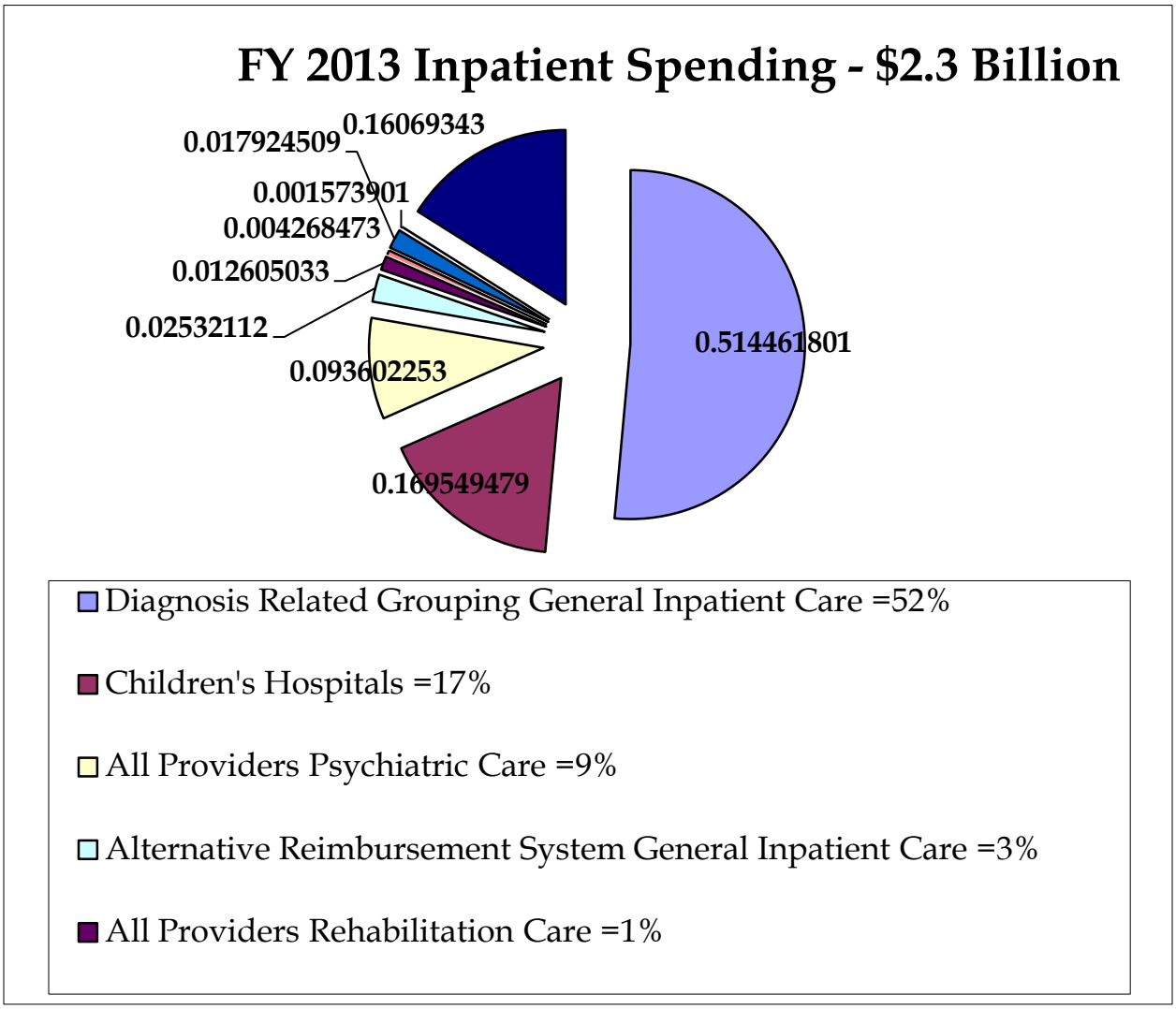
. Inpatient Hospital Services - General Revenue Fund (GRF)

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 2013 decreased 3.9 percent to $1.9 billion from the 2012 amount of $2.0 billion and utilization decreased by 34%. The decrease in

utilization in FY13 is due in part to the movement of individuals to managed care, as well as the hospital's response to the Department's Potentially Preventable Readmission Policy.

The average length of stay for all providers and claims remained the same. The base payments decreased by about 3.9 percent and there was a 7 percent decrease in static payments. Consequently, the overall decrease in reimbursement for hospitals was 4 percent, down to $2.3 billion from $2.4 billion in fiscal year 2012.



Outpatient Hospital Services – GRF

Ambulatory Care Services

Outpatient spending for fiscal year 2013 decreased approximately 13 percent, primarily related to the shifting of seniors and Disabled Adults to the Integrated Care Program and shifting of claims to managed care organizations. Also, Ambulatory Procedure Listing (APL) Group 6 (Outpatient Therapies) are now being paid on the fee schedule, outside of the institutional services billed through the APL.

Total date of service outpatient spending for fiscal year 2013 was $665 million. The majority of general hospital outpatient claims fall into one of the following five Ambulatory Procedure Listings: Group 1-Surgical; Group 2-Diagnostic and Therapeutic; Group 3-Emergency Department Services; Group 4-Observation Services; Group 5-Psychiatric Services

The graph on the following page depicts total Outpatient spending in fiscal year 2013, 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 2013 Total Outpatient Payments by Category

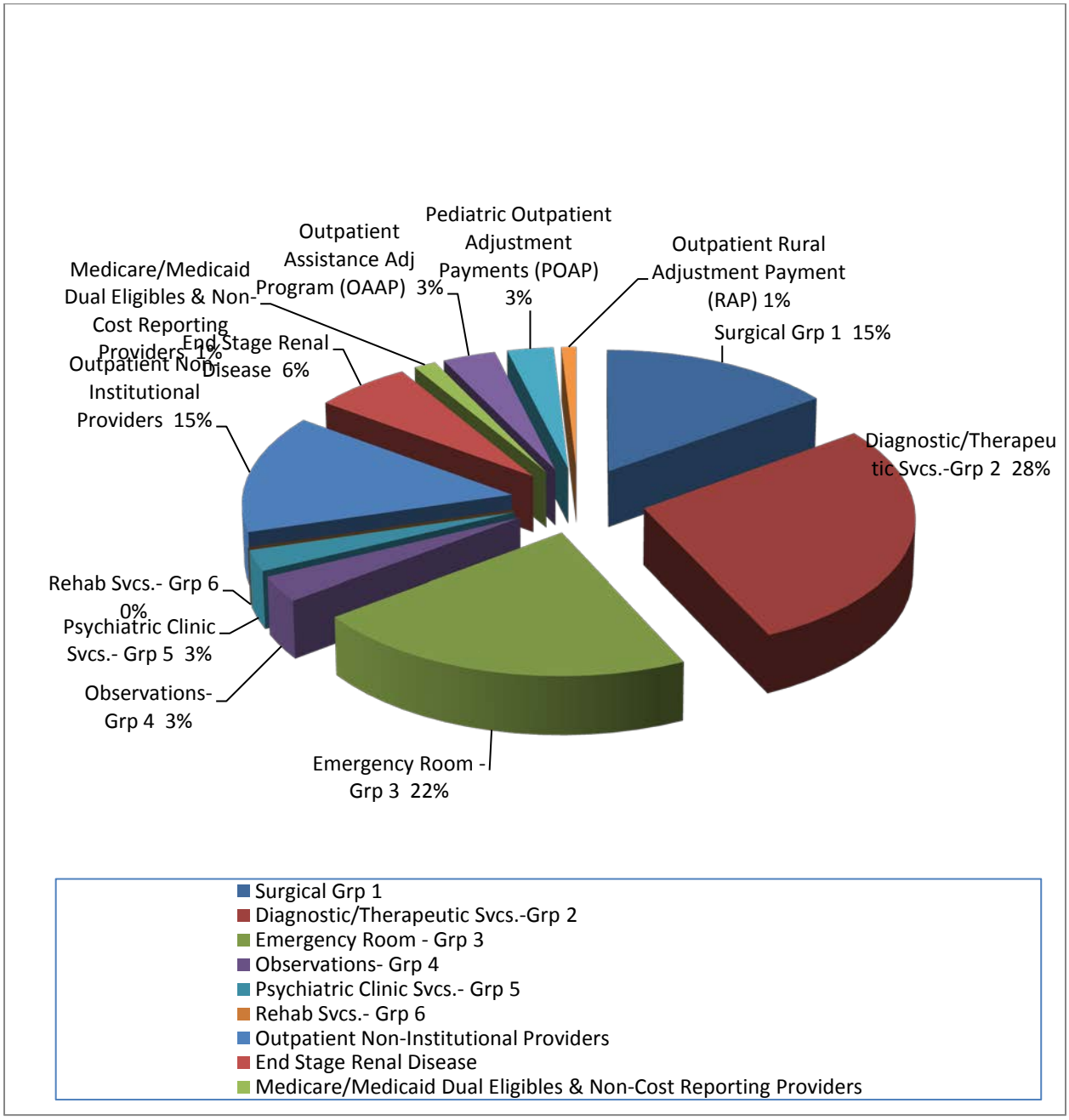
Inpatient Static Payments

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 2013, approximately $227 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 2013, this program distributed approximately $42 million to 40 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 2013, four qualifying rehabilitation hospitals received a little over $11.9 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 2013, 30 qualifying hospitals received approximately $158 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 2013, 87 qualifying hospitals received approximately $14.5 million in payments through this program.



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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 2013, the program paid approximately $4.2 million to six acute care facilities with specialized psychiatric care units.

Rural Adjustment Program

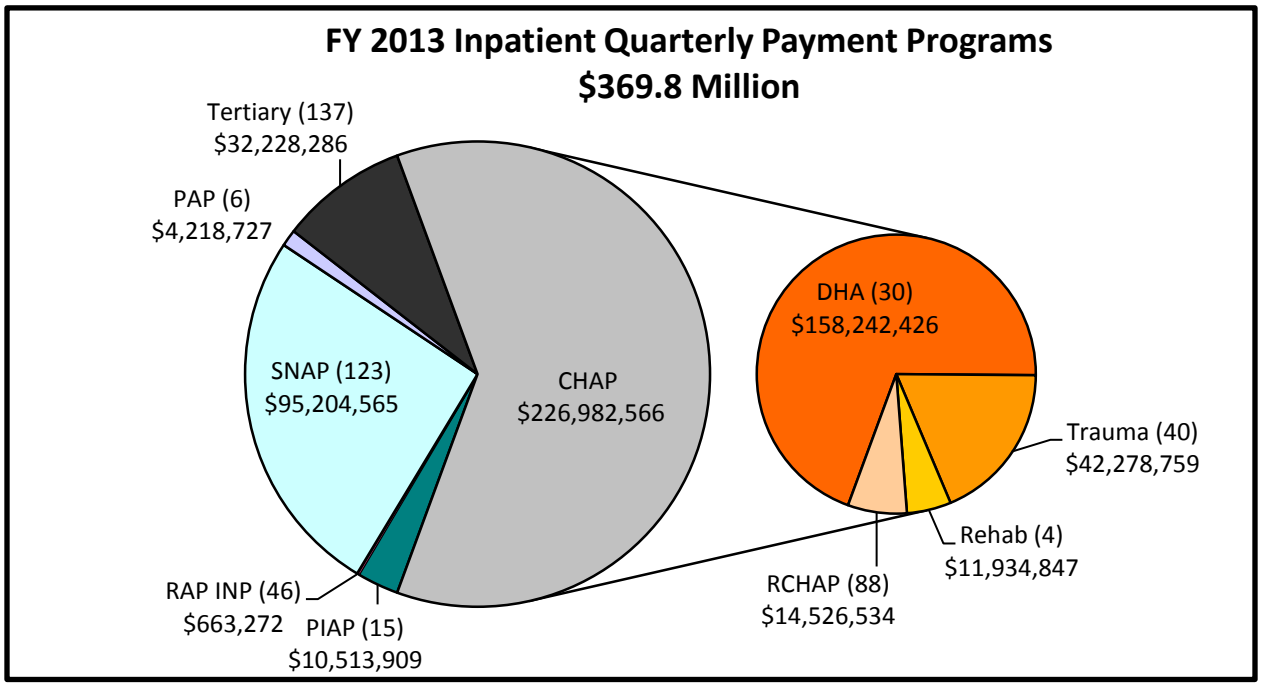
The Rural Adjustment Program provides additional funds to help close the cost coverage gap for hospital providers in rural areas, who have been deemed by the Department of Public Health, as critical to the provision of healthcare in Illinois. The program is divided into two distinct components to recognize 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 2013, a total of 46 providers qualified for the inpatient portion of the program with payments totaling approximately $663,000.

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 2013, a total of 123 providers qualified for the program with payments totaling $95million.

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 2013, with payments totaling approximately $32 million.



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 2013, OAAP payments of $22.6 million were paid to 9 hospitals.

Pediatric Outpatient Assistance Payments

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 2013, the program paid $19.7 million to seven separate children's hospitals.

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 2013, a total of 53 providers qualified for the inpatient portion of the program with payments totaling approximately $6.3 million.

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 2013, 78 hospitals qualified for the DSH adjustment with a total spending of $5 million. In addition, three 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 $92.9 million in federal fiscal year 2013 and the University of Illinois was paid $25.7 million. The average DSH payment for hospitals other than state operated psychiatric facilities and the University of Illinois was $5.83 per DSH day in fiscal year 2013, a decrease from the $7.44 per DSH day paid in fiscal year 2012.

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. Nineteen hospitals qualified for DSH payments in 2013, 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, 89 hospitals qualified for MPA payments with rates ranging from $48.19 to $315.14. Twenty-one children's hospitals received MHVA payments of $231.30 per day, and 68 other hospitals received MHVA payments of $115.65 per day.

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.

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XI 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 submitt to the Department each year. The nursing component is based on federally mandated assessment, Minimum Data Sets (MDS), based clinical information. MDS-based clinical information is used to update case-mix changes in the nursing component 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 $129.62 on June 30, 2013.

P.A. 098-0104 directs the Department to redesign its nursing rate methodology by January 1, 2014 based on the Federal RUG-IV 48 grouper methodology. The nursing rate will be based on a measure of a nursing facility's patient case mix, which reflects the individual needs of patients within the facility and the actual services being provided to the patients. A quarterly MDS assessment for each Medicaid-eligible resident is used to determine the average residents need and service levels within each nursing facility. This factor, when combined with geographic location of the facility and the nursing rate in effect on 07/01/2012, provides the basis for determining the direct care reimbursement rate.

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 (89 Ill. Adm. Code 153.100). In fiscal year 2013, 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. Three newly certified facilities received initial rates in FY13.
- *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 91 facilities in fiscal year 2013.
- *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 did not result in rate revisions for any homes.

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. During FY 2013 the waiver was renewed by the federal CM/MS for five years beginning July 1, 2012.

During fiscal year 2013, 9,179 unduplicated Medicaid eligible residents participated in the program. At the end of fiscal year 2013, there were 140 SLFs, with a total of 11,174 apartments, in operation. This was a three percent increase in the number of SLFs and a three percent increase in the number of apartments available from the previous year. There are 23 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.

Supportive Living Facilities provide an assisted living-style setting that offers an individual who has been determined to be at risk of nursing facility admission an alternative to prevent or delay admission to the more restrictive and costly nursing facility setting.

During Fiscal Year 2013 rule revisions were made to delink the established SLF reimbursement rate from 60 percent of the average nursing facility rate. On average, 60 percent of SLF residents are Medicaid eligible.

XII REIMBURSING CARE COORDINATION PLANS

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 voluntary 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 dental services, optical services, including services provided by an optometrist, nursing facilities services after the first 90 days, and several minor specialized services.

Integrated Care Program

Under the Integrated Care Program, the MCOs are reimbursed on a capitation basis for the entire spectrum of Medicaid covered services, including physician and specialist care, hospitalization, pharmacy, laboratory, dental, 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 11 quality metrics for HEDIS 2013, calendar year 2012 measurement. 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. Baseline measurements using calendar year 2010 data were used to calculate the measures qualifying for incentive pool payments for calendar year 2012 data, the first measurement year reported by the ICP. The integrated care plans are not eligible to earn incentive pool payments if they do not meet a minimum performance standard.

The ICP P4P measures address behavioral health, dental care, diabetes care, congestive heart failure, coronary artery disease, pharmacy management to prevent worsening of chronic obstructive pulmonary disease (COPD), ambulatory care follow-up after inpatient discharge and ED visits, and ED utilization. For HEDIS 2013 Aetna improved in 10 P4P measures and met the Department's performance goal in 5 measures. IlliniCare improved in 4 P4P measures, met the Department's goal in 3 measures but fell below the minimum performance standard in 5 measures and therefore was not eligible for incentive pool payments.

Primary Care Case Management – Illinois Health Connect

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

Under the IHC Bonus Payment for High Performance Program, qualifying IHC PCPs are eligible to receive annual bonus payments for each qualifying service under a bonus measurement. The bonus program increases the quality and access to care for enrollees by encouraging PCPs to provide primary and preventive services in accordance with the quality measurements and drives 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

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 2012 Bonus program, the Department issued over $5 million in bonus payments to qualifying PCPs.

Care Coordination Entities (SPDs and CCMNs)

Care Coordination Entities receive a monthly care management fee for coordination care services. Providers participating in a CCE network will receive fee-for-service payments for medical services rendered in accordance with Department reimbursement policies. Primary Care Physicians (PCPs) participating in a CCEs network must be enrolled as a PCP in the Illinois Health Connect (IHC) Program. These PCPs will continue to receive the monthly IHC care management fee for each participant they accept as a patient. The fee is paid directly to the enrolled PCPs on a capitated basis for each person whose care they are responsible to manage; $3.00 per adult and $4.00 per adult with disability or elderly adult enrollee. PCPs in a CCEs network will also qualify for the IHC Bonus Program.

XIII. PHARMACY PROGRAM

In accordance with federal Medicaid law, 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 Illinois State Medical Society and their Committee on Drugs and Therapeutics provides clinical reviews and advisory recommendations regarding which drugs should require prior authorization. This panel meets quarterly for the purpose of conducting drug reviews.

Reimbursement Methodology

During fiscal year 2013, the reimbursement rate for single-source medications (i.e., brand name) was Wholesale Acquisition Cost (WAC) plus a dispensing fee of $2.40. Multi-source medications (i.e., generics) were reimbursed at WAC plus a dispensing fee of $5.50. The Department's maximum price for each drug continues to be the lesser of WAC, the Federal Upper Limit, the State Maximum Allowable Cost (SMAC), or the pharmacy's usual and customary charge.

In fiscal year 2013, the Department continued to contract with Goold Health Systems to develop and maintain a comprehensive listing of accurate SMAC reimbursement rates. In addition, the department implemented SMAC prices on brand name drugs, including many high-cost specialty drugs. The Department provides public notice of proposed revisions and additions to monthly SMAC rates at least 14 days prior to effective dates. This policy ensures that pharmacy providers may review and, if necessary, appeal the adequacy of SMAC rates before final rates are implemented. Proposed and final SMAC rates can be found at www.ilsmac.com

Four Prescription Policy

Under the SMART Act, the Department implemented the Four Prescription Policy, which requires that participants obtain prior approval for prescriptions after they have filled four prescriptions in the

preceding 30 days. The Department began phasing in this requirement in September of 2012. The purpose of the four prescription policy is to have providers review their patients' entire medication regimen and, where possible and clinically appropriate, reduce duplication, unnecessary medications, and polypharmacy. Pharmacist reviews under the Four Prescription Policy identified opportunities to improve efficacious drug therapy. Since inception of the policy, 42 new utilization control edits have been implemented. The edits address duplicate therapy, drug-drug interactions, inappropriate use, quantity, and duration of therapy. Additional information on the Four Prescription Policy is available on the Department's **Error! Hyperlink reference not valid.** website at http://www.hfs.illinois.gov/pharmacy/

Specialty Drug Use

Under the SMART Act, the Department implemented utilization controls, including prior approval requirements, on several specialty drugs in the following classes: immunosuppressive agents, erythropoietin stimulating agents, HIV medications, hepatitis C agents, and oncology agents. The goals of the specialty drug program are to encourage the use of the most cost effective medications where possible and clinically appropriate, and ensure utilization is consistent with treatment guidelines.

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Hemophilia Care Management Program

Under the SMART Act, the Department implemented quality and utilization control initiatives for patients with hemophilia receiving blood factor. In August of 2012, the Department implemented the Hemophilia Care Management Program. Under this program, pharmacies must sign a Standards of Care Agreement (SOCA) in order to dispense blood factor to Medicaid participants. In December 2012, the Department implemented a prior approval requirement for blood factor products to ensure proper utilization. Further information can be found on the Department's website at **Error! Hyperlink reference not valid.Error! Hyperlink reference not valid.**http://www.hfs.illinois.gov/pharmacy/hemo.html

Third Party Liability – Cost Avoidance

Historically, Illinois Medicaid has enforced cost avoidance in pharmacy through "pay and chase," meaning that if a participant had third party coverage, the department would pay the pharmacy claim and then pursue reimbursement from the third party. Effective July 1, 2012, the department began requiring pharmacy providers to bill the third party first when a participant has third party coverage. If a pharmacy did not report third party payment on a pharmacy claim, the claim rejected instructing the pharmacy to bill the third party first. For dates of service during FY13, $33M in third party payment was reported on pharmacy claims. This is an increase from $17.2M reported on claims with dates of service during FY12.

Drug Prior Approval System

The Department implemented a web-based drug prior approval system in FY12. In FY13, the Department expanded the system to allow providers to enter a drug prior approval request electronically directly into the Department's Drug Prior Approval System through our Medical Electronic Data Interchange (MEDI) System. In addition, providers are able to use this system to check the disposition of their requests.

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 enrolled manufacturer's entire list of covered outpatient drugs. 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.

Preferred Drug List/Supplemental Rebate Program

The Department continues to develop and maintain a Preferred Drug List (PDL). Development of the PDL is based upon clinical efficacy, safety, and cost effectiveness. In PDL development, The University of Illinois at Chicago's College of Pharmacy performs the clinical analysis of each therapeutic class of drug under review and prepares monographs. The Department develops recommendations based on efficacy and safety data contained in the clinical monographs, along with the net cost data. 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. Through the PDL process, 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 rebate program. In fiscal year 2013, the Department collected approximately $14 million in state supplemental rebates from drug manufacturers.

Illinois Average Wholesale Price (AWP) Settlements

In 2005, Illinois filed a lawsuit against drug companies related to inaccurate drug pricing that resulted in significant overpayment for drugs in the Medicaid program. This lawsuit continued throughout FY13. Since the initial filing, HFS staff has provided information and expertise through discovery, responses to interrogatories, depositions, and testimony. During FY13, two additional drug manufacturers settled with the state for a total of $81.5M. This brings the total settlement amount to approximately $164M at the end of FY13. The lawsuit is ongoing.

XIV, 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 292,500Illinois school children participating in the School-Based Health Services program received direct medical services during fiscal year 2013. Local Education Agencies received reimbursement of more than $113.6 million for their costs to provide these services and more than $50.1 million for their administrative costs. In addition, the School-Based Health Services program

generated more than $1.5 million in revenue for the state. For more information visit: <https://www.illinois.gov/hfs/MedicalPrograms/sbhs>

XV. 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 2013, the RHC program had 261sites in Illinois. This reflects an increase of 12 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 2013, there were 443FQHC sites throughout Illinois. This reflects an increase of 49 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.

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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 continued to be administered by First Transit, Inc. during FY13. The administrator is responsible for the screening and prior approval adjudication process for all non-emergency medical transportation. During the fiscal year 2013, the program processed 543,500 non-emergency transportation prior approval requests. The reduction in NETSPAP transactions between 2012 and 2013 is due to the transition of Medicaid participants to care coordination entities. An RFP to administer the NETSPAP was published in November 2013, with a contract effective date anticipated for mid-2014.

As a result of *Public Act 097-0689(pdf)*, referred to as the Save Medicaid Access and Resources Together (SMART) Act, and subsequent changes to *89 Ill. Adm. Code Section 140.491*, the department implemented a new law affecting facilities, most commonly hospitals, discharging Medicaid patients by ambulance effective July 1, 2013. The new law requires the treating provider (or their designee) to complete a medical certification justifying the medical necessity of the ambulance-level transport.

XVI. 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 and revised the core set in May 2013 and again in December 2013. In October 2013, the department released the 2012 CHIPRA Data Book, which was developed through the CHIPRA Quality Demonstration Grant to report on the CHIPRA core measure set. The CHIPRA Data Book represents the first time the state has publicly reported on a comprehensive set of quality measures over time. The state is soliciting public input into the CHIPRA Data Book, which serves as a template for future annual reporting of the CHIPRA core set and a growing array of other quality measures. The CHIPRA Data Book is available at:
http://www2.illinois.gov/hfs/SiteCollectionDocuments/2012CHIPRADatabook.pdf

In December 2013, the department reported to CMS on 25 or the 26 core measures and intends to use those measures to drive quality improvement at the state level, within health plans and among providers.

The CHIPRA core set requires reporting of a statewide rate (including both Titles XIX and XXI populations across all delivery systems) for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). In addition, effective with December 2013 reporting, CMS also requires states to separately report the CAHPS for the Title XXI population in the CHIP Annual Report. To comply with these requirements, the department amended its contract with Health Services Advisory Group (HSAG), the department's External Quality Review Organization (EQRO);, which is a certified CAHPS vendor, to administer and report on the statewide CAHPS annually.

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.

As the department works to implement a coordinated/managed care delivery system, a standardized core set of measures is under development with many of the CHIPRA measures included.

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). During 2013, one measure was retired and three additional measures were added to the core set. 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. The Emergency Department Utilization Workgroup met during 2013 and recommendations for reducing inappropriate emergency department utilization were submitted to HFS in January 2014 for consideration. The Workgroup's recommendations were developed to comply with the following criteria: Easy to adopt, can be implemented quickly, requires minimal additional resources, can be implemented within existing rules and laws, and consistent with HFS health care delivery system changes. Many of the recommendations are in alignment with strategies released by CMS in a State Health Officials Letter dated January 15, 2014.

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, the Illinois Department of Healthcare and Family Services (HFS) executed an EQRO contract with Health Services Advisory Group (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 Managed Care Entities (MCEs) which include all Care Coordination programs developed by HFS including Voluntary Managed Care Organizations (VMCOs), the Integrated Care Program (ICP), Medicare-Medicaid Alignment Initiative (MMAI), Care Coordination Entities (CCEs), Accountable Care Entities (ACEs), and other programs developed under the Department's Innovations Program.

HFS has three contracted MCOs in the Voluntary Managed Care Program and nine MCOs in the ICP. On March 1, 2014, HFS will roll out MMAI which includes eight MCOs. HFS currently contracts with five CCEs and continues to expand other care coordination programs under the Department's 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 staff 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 (SPDs and CCMNs), Medicare-Medicaid Alignment Initiative and expand on performance goals, measurable targets and satisfactory progress toward those targets. HFS is currently updating the Quality Strategy for 2013/2014.

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 provides HFS with an annual EQR Technical Report describing the manner in which data from External Quality Review activities were 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.

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 2013, non-certification of medically unnecessary services resulted in direct cost savings of $24.5 million for an estimated cumulative savings of $261.5 million since it began contracting with HFS as the Illinois Medicaid Quality Improvement Organization in 2002. In FY13, the return on investment is estimated at $4.21 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 2013, 30,125 retrospective reviews failed quality screens and were referred to a physician reviewer. During fiscal year 2013, 13% of all physician referrals resulted in medical necessity denials which represents a slight decrease in the overall denial rate compared with the prior fiscal year.

Review Activity

In fiscal year 2013, eQHealth conducted 184,893 concurrent and prepayment reviews associated with 102,309 hospitalizations which is a 15.7% decrease in total volume as compared to the previous

reporting period. A total of 90,972 child and adolescent psychiatric hospitalization reviews were performed which represents 48.2% of the total volume of all hospitalizations concurrently reviewed.

New Initiatives for 2013

The two new review activities were implemented in FY13:

- Detoxification Services – beginning in July, 2013, inpatient detoxification admissions were limited to one every 60 days. Detoxification services continue to be the most prominent clinical service for readmissions despite legislative changes which limit the timeframe for readmission. It is also important to note that this category of clinical service serves the fewest number of participants but is associated with the highest rate of admissions.
- Medically unnecessary cesarean sections – In March, 2013, eQHealth began evaluating the medical necessity of cesarean deliveries. A total of 249 medical records were selected for review during the last quarter of FY13 of which only 230 were received. Of the 230 cases reviewed, only 3 cases were determined to be medically unnecessary. Payments for cases determined to be medically unnecessary are reduced to the lower vaginal delivery rate. If the record is not received, the review is canceled and no payment is made. During this period, 19 records were not received.

Special Projects, Collaboration, and Report Activity

During this fiscal year, eQHealth continued to support HFS by performing special projects and ad hoc data analyses which assisted HFS in making informed program decisions. eQHealth's expertise serves to support, advocate, and achieve 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 2013, A total of 8,803 LTAC reviews were conducted for all LTAC hospitalizations. Medical/Surgical reviews comprised 87 percent of the review volume while 13 percent of the review volume was attributed to psych admissions. LTAC hospitals' certified days totaled 56,750 with 607 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, our contractors 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.

Over the past two years, 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 as the departments federally funded Quality Imporvement Organization.

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 2013, eQHealth conducted comprehensive provider reviews for five waivers and 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) at the Department of Human Services.

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, the Department of Human Services and the Department on Aging. 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 2013 Activity

During Calendar Year 2013 (the reporting period for the OIG), the OIG successfully implemented legislative and enforcement initiatives that resulted in $121.0 million dollars in cost savings, avoidance and recoupment for the taxpayers of Illinois. This represents a nearly $30.0 million dollar increase over CY2012 ($89.0m) and $50.0 million over CY2011 ($70.6m). See our annual reports at: http://www.state.il.us/agency/oig/default.asp

XVII 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
ACA Adults – under the Affordable Care Act (ACA), and Public Act 98-104, adults' age 19-64 who have income up to 138 percent of the federal poverty level (monthly income of $1,321/individual, $1,784/couple) can qualify for Medicaid starting in January 2014.

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 2013, 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: www.allkids.com and www.familycare.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 482 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 89 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 ($2,610 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 $2,611 and $2,944 a month for a family of four).

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 $2,945 and $3,925 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 $3,926 and $5,888). 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 $2,611 and $3,925 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 $3,925 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 2013, ? 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

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 March 31, 2013 an unduplicated total of 177,190 women had received family planning services through Illinois Healthy Women. Women have no co-payments for family planning services. Individuals may learn more about IHW at: www.Illinoishealthywomen.com

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.

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

During fiscal year 2013, HBWD provided health coverage to a monthly average of 750 employed people. Comprehensive program information, as well as a downloadable application can be found at www.hbwdillinois.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 $7,080for a single person and $10,620 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

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.

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.

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

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

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 2013, 1,043 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.

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.

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 2013, 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 2013, 18,830 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 federal fiscal year 2013, the renewal for this waiver was approved, with an effective date of July 1, 2012. 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 2013, 1,388 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 2013, 4,193 persons were served.

In federal fiscal year 2013, the renewal for this waiver was approved, with an effective date of July 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 2013, there were 1,350 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 April 27, 2012 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 renewal submission included sampling methodology and performance measures 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 20,504 individuals during fiscal year 2013. 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 49,784 seniors during federal fiscal year 2013.

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. During FY 2013 the waiver was renewed by the federal CM/MS for five years beginning July 1, 2012.

During fiscal year 2013, 9,179 unduplicated Medicaid eligible residents participated in the program. At the end of fiscal year 2013, there were 140 SLFs, with a total of 11,174 apartments, in operation. This was a three percent increase in the number of SLFs and a three percent increase in the number of

apartments available from the previous year. There are 23 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.

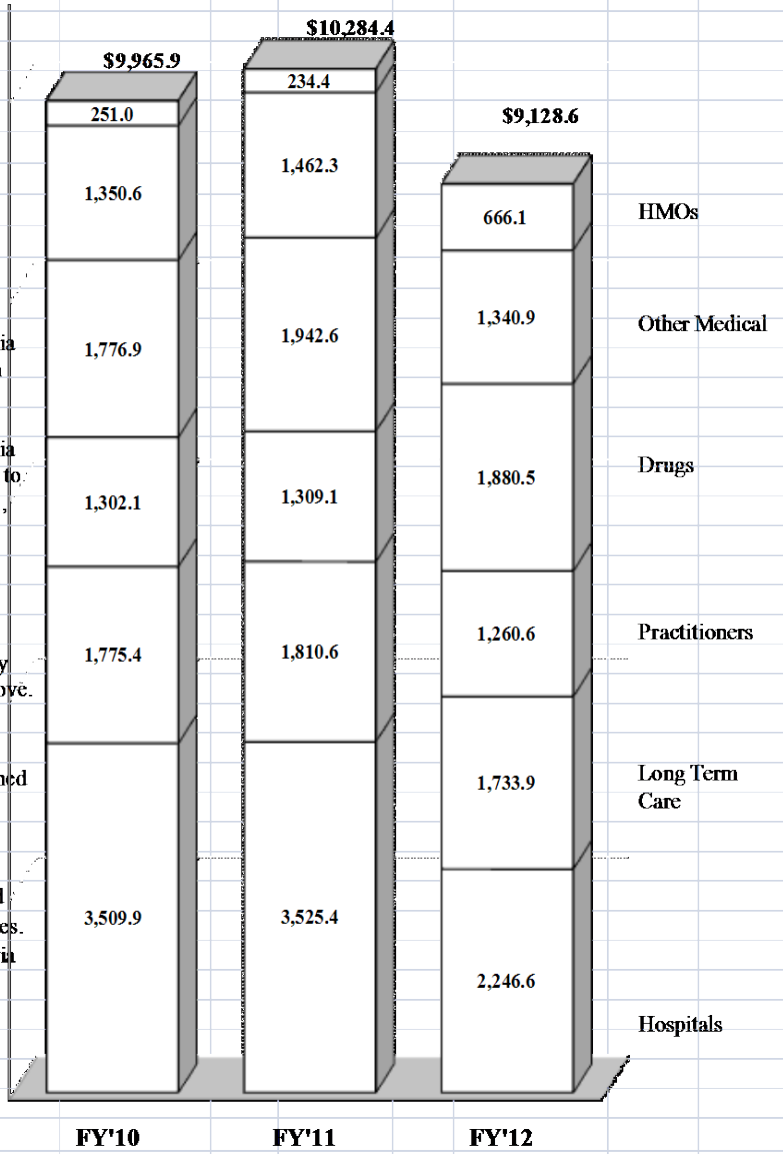
Supportive Living Facilities provide an assisted living-style setting that offers an individual who has been determined to be at risk of nursing facility admission an alternative to prevent or delay admission to the more restrictive and costly nursing facility setting.

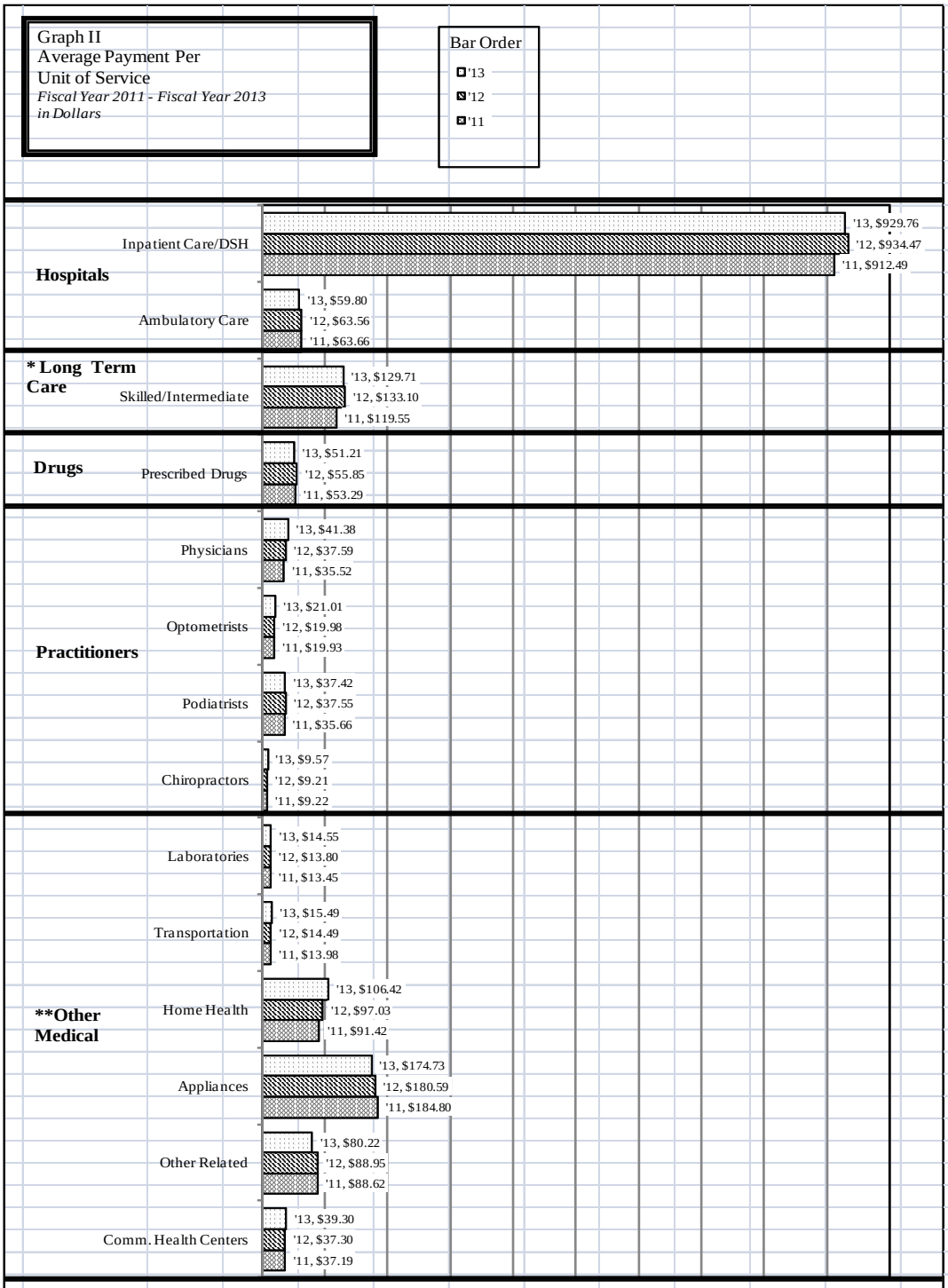
During Fiscal Year 2013 rule revisions were made to delink the established SLF reimbursement rate from 60 percent of the average nursing facility rate. On average, 60 percent of SLF residents are Medicaid eligible.

XVIII 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.





Notes:

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, DentaQuest) or hospice.

Average payment rate after adjustments for patient co-payments, third party liability, 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 FY13.

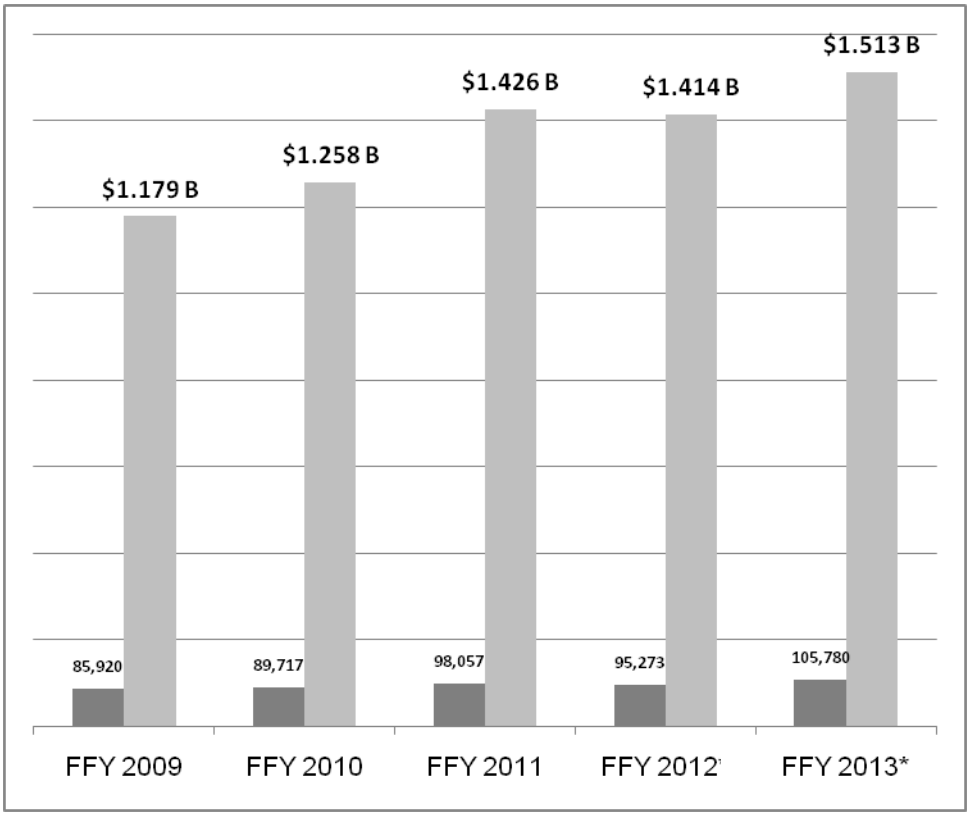
* Long Term Care rate data reflects charge rate, which includes patient and third party contributions. Supportive Living Facilities not included.

** Home health care rate increase in FY13 reflects 12 months of payments for APN services switched for payment from HHC to Physicians appropriation.

Graphs Prepared By: Division of Finance

Data Source: Division of Finance

Graph III
Medicaid Waiver
Persons and Expenditures
Federal Fiscal Year 2009 – Federal Fiscal Year 2013



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, Division of Specialized Care of Children, DHS and HFS.

* FFY 2013 numbers are based on data available as of February 7, 2014.

XIX. 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 2011 -Fiscal Year 2013
Dollars in Thousands

	FY'11 Expenditures	Percent	FY'12 Expenditures	Percent	FY'13 Expenditures	Percent
Total	**$10,284,430.3**	**100.0%**	**$9,128,608.1**	**100.0%**	**$11,577,062.8**	**100.0%**
Hospitals [1]	**3,525,388.6**	**34.3%**	**2,246,564.5**	**24.6%**	**4,222,599.6**	**36.5%**
Inpatient	N/A		N/A		N/A	
Ambulatory Care	N/A		N/A		N/A	
Long Term Care [2]	**1,810,618.9**	**17.6%**	**1,733,914.1**	**19.0%**	**2,120,445.8**	**18.3%**
Practitioners	**1,309,095.1**	**12.7%**	**1,260,642.4**	**13.8%**	**1,381,022.4**	**11.9%**
Physicians	986,389.5	9.6%	907,878.8	9.9%	1,101,322.6	9.5%
Dentists	266,748.9	2.6%	295,694.6	3.2%	233,014.0	2.0%
Optometrists	46,889.4	0.5%	47,450.5	0.5%	42,239.7	0.4%
Podiatrists	7,549.4	0.1%	8,217.8	0.1%	3,909.9	0.0%
Chiropractors	1,517.9	0.0%	1,400.7	0.0%	536.2	0.0%
Drug	**1,942,633.4**	**18.9%**	**1,880,529.9**	**20.6%**	**1,586,813.6**	**13.7%**
Other Medical	**1,456,351.0**	**14.2%**	**1,334,716.2**	**14.6%**	**1,428,930.9**	**12.3%**
Laboratories	59,372.2	0.6%	51,948.2	0.6%	77,520.6	0.7%
Transportation	85,946.0	0.8%	66,738.5	0.7%	83,255.0	0.7%
SMIB/HIB/Expansion [3]	390,931.5	3.8%	389,452.8	4.3%	380,212.9	3.3%
Home Health Care/DSCC	164,106.3	1.6%	151,829.1	1.7%	163,604.9	1.4%
Appliances	92,041.4	0.9%	80,517.4	0.9%	94,308.0	0.8%
Other Related [4]	201,935.1	2.0%	184,650.9	2.0%	163,928.0	1.4%
Comm Health Centers	336,901.9	3.3%	299,162.7	3.3%	291,247.8	2.5%
Hospice Care	89,315.7	0.9%	79,106.4	0.9%	114,932.8	1.0%
Children's Mental Health/SIU ACR	35,800.9	0.3%	31,310.2	0.3%	59,920.9	0.5%
Coordinated Care	**234,369.0**	**2.3%**	**666,072.9**	**7.3%**	**832,343.3**	**7.2%**
Children's Rebate	**5,974.3**	**0.1%**	**6,168.1**	**0.1%**	**4,907.2**	**0.0%**

[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, Medicaid Research and Education Support and Juvenile Rehabilitation 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'13, December 30, 2013.

Table IV
Medicaid Providers
By Type of Service
Fiscal Year 2010-
Fiscal Year 2013

Provider Type	FY'10		FY'11		FY'12		FY'13	
Hospitals								
Cost Reporting	259		258		240		236	
Therapists[1]	4,044		4,467		5,276		4,809	
Clinics[2]	712		714		799		735	
Long Term Care Facilities Total	1,156		1,161		1,160		1,147	
Nursing Facilities		738		734		732		721
ICF/MR		299		300		292		281
Supportive Living Facilities		119		127		136		140
SMHRF[3]		0		0		0		5
Physicians	37,754		39,218		43,151		40,353	
Dentists[4]	4,633		5,267		6,009		6,322	
Optometrists	820		933		1,015		1,073	
Podiatrists	593		605		634		635	
Chiropractors	539		546		567		513	
Pharmacies	2,796		2,849		2,883		2,829	
Laboratories/Portable X-rays	446		474		525		501	
Transportation	1,592		1,719		2,036		1,533	
Home Health Agencies	335		359		454		381	
Managed Care Organizations[5]	3		3		5		5	
Hospice	107		108		116		116	
Durable Medical Equipment	1,391		1,478		1,591		1,314	
Community Health Agency	7		7		7		6	
Other Providers[6]	4,896		5,780		7,092		7,080	
Total Providers	**62,083**		**65,946**		**73,560**		**69,588**	

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 Specialized Mental Health Rehabilitation Facilities.

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

5 Includes MCCNs.

6 "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 2013

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 2013

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:
- 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 2011to 2013

Claims Receipts History

Fiscal Year 2011 to 2013

	FY11	FY12	FY13	% Change FY11-FY13	% of Total Claims FY13
Total Claims Received	90,950,735	97,441,350	93,505,566	2.8%	
Physicians	30,211,937	36,395,611	35,990,730	19.1%	38.5%
Laboratory	1,889,471	2,226,043	2,093,168	10.8%	2.2%
Transportation Services	1,910,150	2,173,410	2,012,903	5.4%	2.2%
Medical Equip/Supply	2,063,634	2,200,533	2,028,600	-1.7%	2.2%
Health Agency	96,147	74,750	84,151	-12.5%	0.1%
Medicare	7,241,365	10,012,804	9,880,086	36.4%	10.6%
Pharmacy	41,551,228	38,333,419	35,643,116	-14.2%	38.1%
Hospitals	5,079,105	5,214,796	4,947,218	-2.6%	5.3%
Long Term Care	817,112	746,919	756,556	-7.4%	0.8%
All Other Categories	90,586	63,065	69,038	-23.8%	0.1%

During fiscal year 2013, 93.5 million medical claims were received and processed by the Department. This was a decrease of 4.2 percent over the number of claims received in fiscal year 2012 and a 2.8 percent increase over claims received during fiscal year 2011.

Of all the claims received in fiscal year 2013, approximately 89.0 million, or 95.1 percent were received via electronic transfer, equal to the 95.1 percent in fiscal year 2012. ***Table VI*** below shows claims receipt history for fiscal year 2011 through fiscal year 2013.

Physician claims accounted for the largest share (39 percent) of total claims received during fiscal year 2013, with pharmacy claims (38 percent), Medicare (11 percent), hospitals (5 percent), and claims for medical equipment/supply, transportation and labs (2+ percent) rounding out the top five receipt categories. Between fiscal years 2011 and 2013, the fastest growing claims category was Medicare showing approximately a 36 percent increase, followed by physicians increasing by 19 percent and lab claims increasing by almost 11 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 2013, the PrePay Pricing Unit reviewed the reimbursement requests for 6.8 million services, no change over the number of services reviewed in fiscal year fiscal year 2012 and 5.6 percent less than the number services reviewed in fiscal year 2011. As a result of the PrePay Pricing Unit's review and pricing of claims, approximately $125.5 million in saving was realized by the Department in fiscal year 2013.

Table VII
Table VII
Home and Community Based-Services Waivers

FFY2013 Capacity, Operating Agency, Waiver Begin/End Dates, Target Populations, Base Services and Waiver

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 *(current waiver extended pending approval of renewal)* **FFY 13** **Cap** 700 **# Served** 614 **Expenditures** $2,270,781	• 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 07/01/07 **End Date** 07/01/10-06/30/15 **FFY 12** **Cap** 280 **Served** 287 **Expenditures** $23,271,523	• 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 07/01/07 **End Date** 07/01/10-06/30/15 **FFY 13 Cap:** 1,400 **Served** 1,388 **Expenditures** $17,185,117	• 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 13 Cap** 1542 **Served** 1,350 **Expenditures** $14,132,182	• 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. Sampling methodology in renewal submission is modeled after Brain Injury waiver. .

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 13 Cap** 19,000 **Served** 18,830 **Expenditures** $602,351,657	• 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** 07/01/12-06/30/17 FFY 13 **Cap** 4,623 **# Served** 4,193 **Expenditures** $64,419,516	• 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 13** **Cap** 35,498 **Served** 20,504 **Expenditures** $264,966,214	• 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 13** **Cap** 48,675 **Served** 49,784 **Expenditures** $390,207,964	• 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, 2013, the Health Benefits/All Kids and the Drug Prior Approval Hotlines had received and handled over 850,000 calls from clients and providers. The Health Benefits/All Kids hotline responded to over 537,000 calls and the Drug Prior Approval/Refill Too Soon Hotline answered almost 313,000 calls. The hotline staff also process prior approval/refill too soon/4 script limit requests received via facsimile. In this same time period, over 429,000 requests were entered for review by pharmacy staff.
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.