



Presentation to Senate Appropriations Committee

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HFS Mission

- To empower Illinoisans to lead healthier and more independent lives through the “Triple Aim” by improving the quality of healthcare, improving health outcomes and reducing the growth in healthcare costs; and
- To enhance children’s well-being and families’ self-sufficiency by establishing and enforcing child-support obligations.

Medical Programs FY 2015 Goals

- Redesign the Medicaid healthcare delivery system
- Implement the Affordable Care Act (ACA)
- Rebalance the long-term care system
- Continue program integrity initiatives
- Manage Medicaid budget growth

Providing Healthcare Coverage

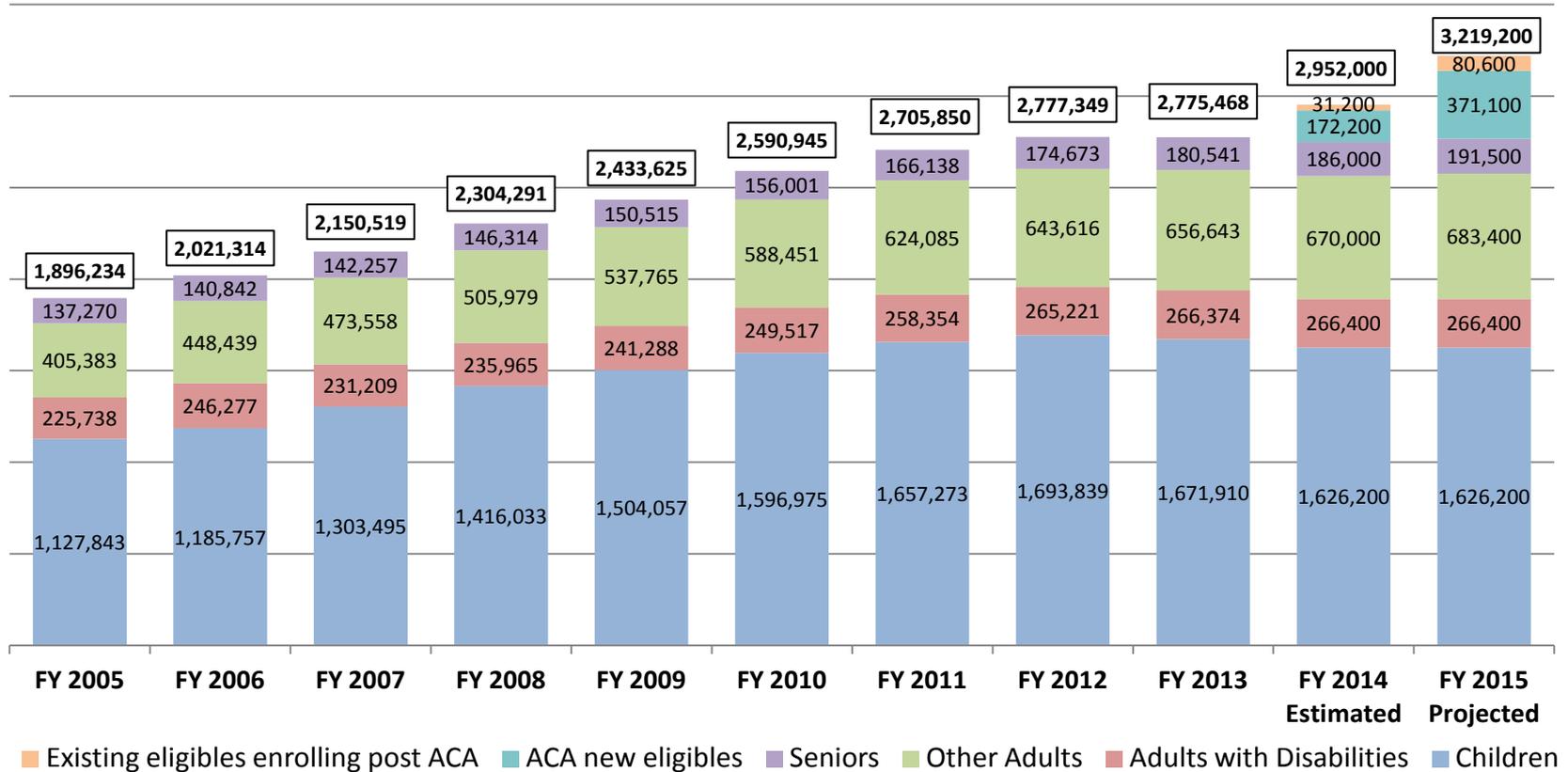
- HFS is the largest insurer in Illinois
- Current Medical Programs Enrollment (11/30/13): 2.76 million*
 - Children: 1.60 million
 - Seniors: 182,700
 - Adults with Disabilities: 261,800
 - Other Adults: 634,500
 - ACA Adults: 80,600 (County Care)

** Excludes enrollees in partial benefit programs*

Enrollment Under ACA

- Originally estimated 509,000 enrollees post-ACA by 2017, but current surge of enrollment is higher than anticipated
- Newly eligible “ACA Adults” – 100% federal match
 - 350,000 estimated enrollment by the end of FY 2014
 - 385,000 projected enrollment by the end of FY 2015
- Medicaid clients who were previously eligible, but had not yet applied – 50/50% match
 - 80,000 estimated by end of FY 2014 – in addition to historical enrollment
 - 85,000 projected additional enrollment by end of FY 2015

Medical Programs Average Enrollment

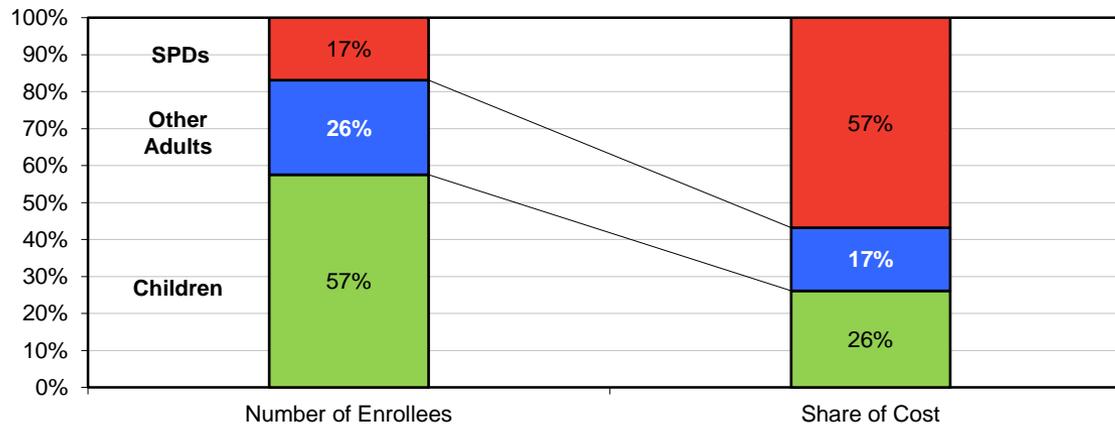


Reflects average annual enrollees

Excludes enrollees in partial benefit programs

Small % of Medicaid Clients Incur Majority of Medicaid Costs

17% of recipients who are Seniors and Persons with Disabilities (SPD) result in 57% of Medicaid costs (all agencies) – they have most complex health/behavioral health needs



Medicaid costs are driven by the number and type of recipients (eligibility rules), their service utilization patterns and the established reimbursement methodologies for those services.

Illinois State Mandate

- 2011 Medicaid reform law (P.A. 96-1501) mandates 50% of clients to be enrolled in “care coordination” by 1/1/15
- Even without state mandate, we believe that care coordination is needed to achieve the Triple Aim:
 - Improving the quality of care
 - Improving the health of populations, and
 - Reducing the growth in health care costs
- We use “care coordination” and “managed care” interchangeably - it’s about “managing” care

Our Unique Structure: Models of “Managed Care Entities”

- Testing different models for 5 different Medicaid populations
 - Seniors and Persons with Disabilities (SPD) – Medicaid only
 - Seniors and Persons with Disabilities (SPD-duals) -- Medicare/Medicaid
 - Children with complex medical needs
 - Children/family & caregivers
 - Newly eligible ACA Adults

- 4 different models, generally called “Managed Care Entities”
 - Managed Care Organizations (MCO)
 - Managed Care Community Networks (MCCN)
 - Care Coordination Entities (CCE)
 - Accountable Care Entities (ACE)

What Is Changing With Managed Care?

- Managed care entities organize networks of providers
- Networks include primary care, specialists, hospitals, behavioral healthcare
- Clients select a managed care entity, then stay within network for 1 year
- Patient-centered health homes coordinate care of clients with complex needs
- Multidisciplinary teams focus on clients' holistic needs
- Care coordinators help navigate the system, arrange care transitions and follow-up care
- Electronic health records make care coordination possible with sharing of clinical information
- Payments reward for quality and health outcomes (“value-based purchasing”); transition from fee-for-service to full risk
- Renewed focus on social determinants of health and wellness

Managed Care Roll-Out Plan

- Managed care is mandatory in 5 regions, implemented in stages – about 2 million clients
 - Chicago region – 6 counties
 - Rockford region – 3 counties
 - Central Illinois region - 15 counties
 - Quad Cities region – 3 counties
 - Metro East region – 3 counties
- Clients in rural counties will continue to be in IL Health Connect (fee-for-service) for a while

Managed Care Roll-Out Plan, cont.

- Seniors and Persons with Disabilities – Medicaid only
 - Called Integrated Care Program
 - Offers Service Package I (medical) and II (long-term services and supports, or “LTSS”), as needed
 - Fully implemented in all mandatory regions by September 2014
 - MCOs, CCEs, MCCN

- Seniors and Persons with Disabilities – Duals
 - Called Medicare Medicaid Alignment Initiative (MMAI) – federal demonstration in 2 regions
 - Offers Service Package I and II, as needed
 - Enrollment has begun
 - MCOs only

Managed Care Roll-Out Plan, cont.

- Children with complex medical needs
 - Enrollment to begin in July 2014
 - 3 CCEs (plus other children as below)

- Family health population: children/families or caregivers
 - Enrollment to begin in July 2014
 - ACEs, MCCNs, MCOs

- Newly eligible ACA adults
 - Enrollment began with CountyCare in February 2013; ongoing
 - ACEs, MCCNs, MCOs

Rebalancing Long-Term Care System

- Assisting sister agencies with 3 Consent Decrees
- Applied for and received Balancing Incentive Program (BIP) award, with enhanced federal match, to increase community capacity
 - \$19.5 million included in HFS' FY 2015 budget request
 - \$90.3 million expected for State by September 2015
- Nursing home reimbursement system has been modernized (RUGs)

Continuing Program Integrity Efforts

- Quinn Administration has made it a priority to root out Medicaid waste, fraud and abuse
- State verifies eligibility through data matching
 - Secretary of State driver's license and state identification data
 - Social Security Administration data
 - Automated Wage Verification System data
 - DHS' SNAP and cash assistance data
 - HFS' child support data
 - IL Department of Revenue tax records
 - The Work Number – Income verification service vendor
- State enhanced the annual redetermination process with assistance from Maximus

IL Medicaid Redetermination Project: Phase I

- 234,000 clients (148,000 cases) removed from Medicaid – mainly between March and December 2013
- Maximus reviews focused on clients receiving Medicaid, but not other types of assistance
- Cases reviewed by priority order – based on likelihood client would be found ineligible
- Resulting cancellation rate was 41%
 - Most cases were cancelled due to lack of response to the initial redetermination letter
 - 33% of clients cancelled returned to Medicaid within 3 months of cancellation – when they presented required information for eligibility

IL Medicaid Redetermination Project: Phase II

- HFS and DHS have worked to reorganize the redetermination project to be compliant with AFSCME arbitration resolution and SMART Act
- DHS has hired and trained additional caseworkers and support personnel to staff two main redetermination hubs
- Maximus continues to staff call center, mail room and provides needed software
- In February and March 2014, 35,994 cases were reviewed
 - 50.6% were cancelled
 - 83% were cancelled due to lack of response

Office of Inspector General

- OIG's mission is to prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct in HFS programs
- Fraud Prevention Investigation (FPI) program ensures only those eligible for Medicaid receive benefits
- Long-Term Care Asset Discovery Investigations (LTC-ADI) uncover undisclosed assets and improper asset transfers in the long-term care program
- OIG collects overpayments and seeks sanctions of providers through audits, peer reviews, civil/criminal investigations and advanced data mining

Managing the Medicaid Budget

- Health care inflation is a national issue
 - General health care expenditures have been growing about 4%
 - State Medicaid programs have been growing slightly more than 2% the past couple years
- Illinois base Medicaid costs grew by an average of 6.3% per year from FY 2007 to FY 2011

Managing the Medicaid Budget

- Base Medicaid costs were relatively flat in FY 2012
- Base Medicaid costs declined approximately 6% in FY 2013 (SMART Act)
- HFS projects base Medicaid liability growth (excluding ACA impact and other program modifications) of 2% in FY 2015
- Medicaid budget requires constant attention

Managing the Medicaid Budget

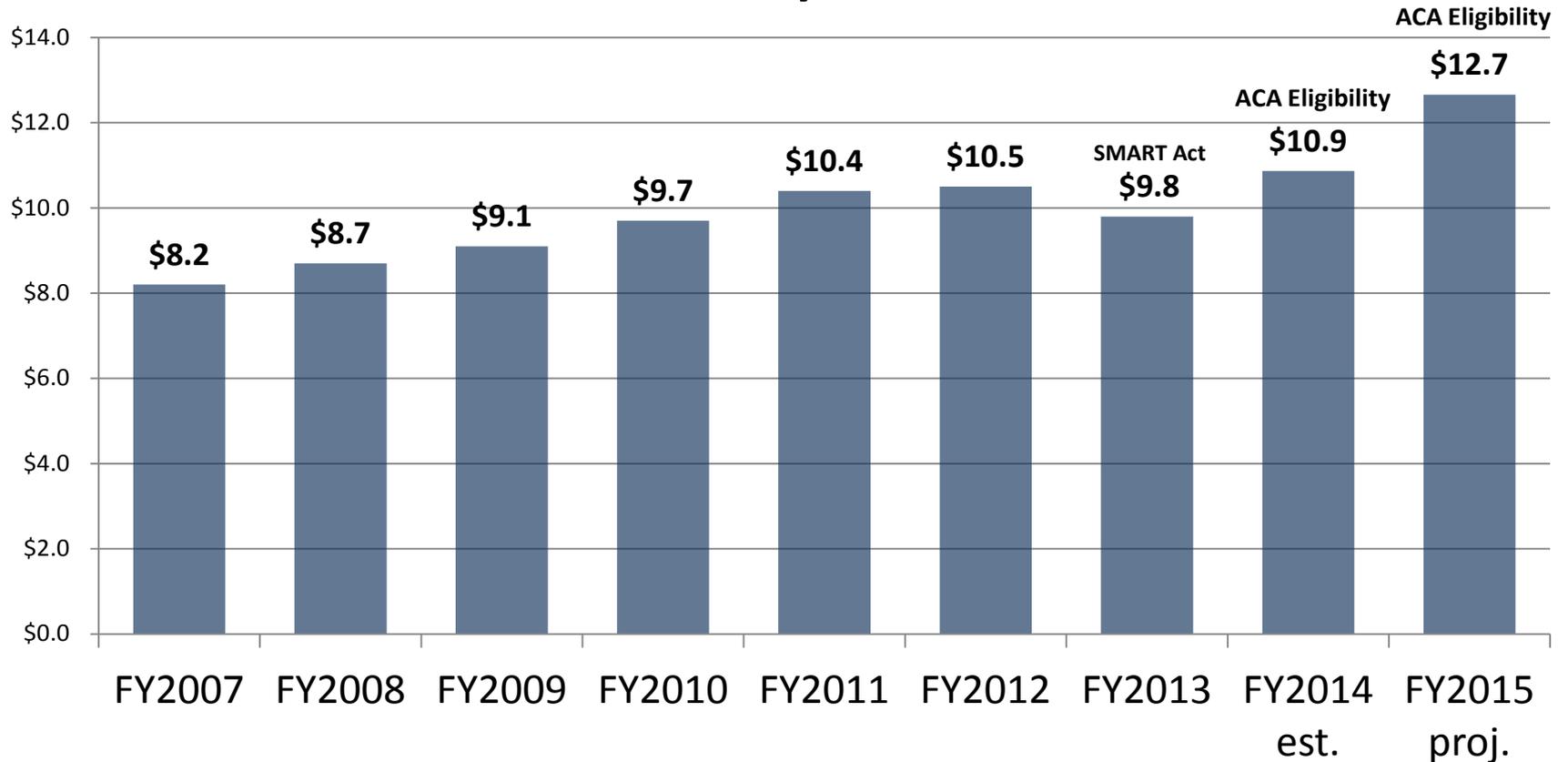
- Section 25 statutory caps:
 - Require payment of GRF and related fund medical bills received by June 30th from current year appropriations
 - Eliminate long “budgeted” payment cycles – cannot push large amounts of unpaid medical bills into future fiscal years
- With Section 25 caps, Governor and General Assembly imposed discipline on spending within Medicaid budget
- HFS is generally processing GRF-related bills to Comptroller in less than 30 days

Managing the Medicaid Budget

- FY 2015 introduced budget will allow HFS to continue meeting Section 25 caps
- Introduced budget is maintenance budget; increases for:
 - \$35m for restoration of adult dental benefits
 - \$60m for care coordination fees
 - \$130m for nursing facility RUGs methodology
 - \$70m for anticipated hospital rate reform transitional payments

Historical Medical Programs Liability GRF and Related Funds

Total Liability in Billions



Child Support Services

- Division of Child Support Services (DCSS) serves both families who receive TANF and Medical Assistance and families who are not receiving government assistance, but still need child support services
 - In FY 2013, for the ninth straight year, the Department achieved collections of more than \$1 billion, with a total of \$1.38 billion – most of it passed on to families
- Child Support services are authorized under Title IV-D of the federal Social Security Act, state law and administrative rules

Child Support Services

- DCSS costs are mainly driven by increases in staffing expenses since child support services functions are administrative in nature
- FY 2015 budget assumes that only 14 cents of every child support services operational dollar comes from GRF; remaining resources include:
 - retained child support collections from clients receiving TANF grants
 - federal performance incentives -- \$15.3M for improved performance in FY 2012
 - federal match -- 66% match rate

Department of Healthcare and Family Services Program Area Appropriations Comparison (Dollars in Millions)

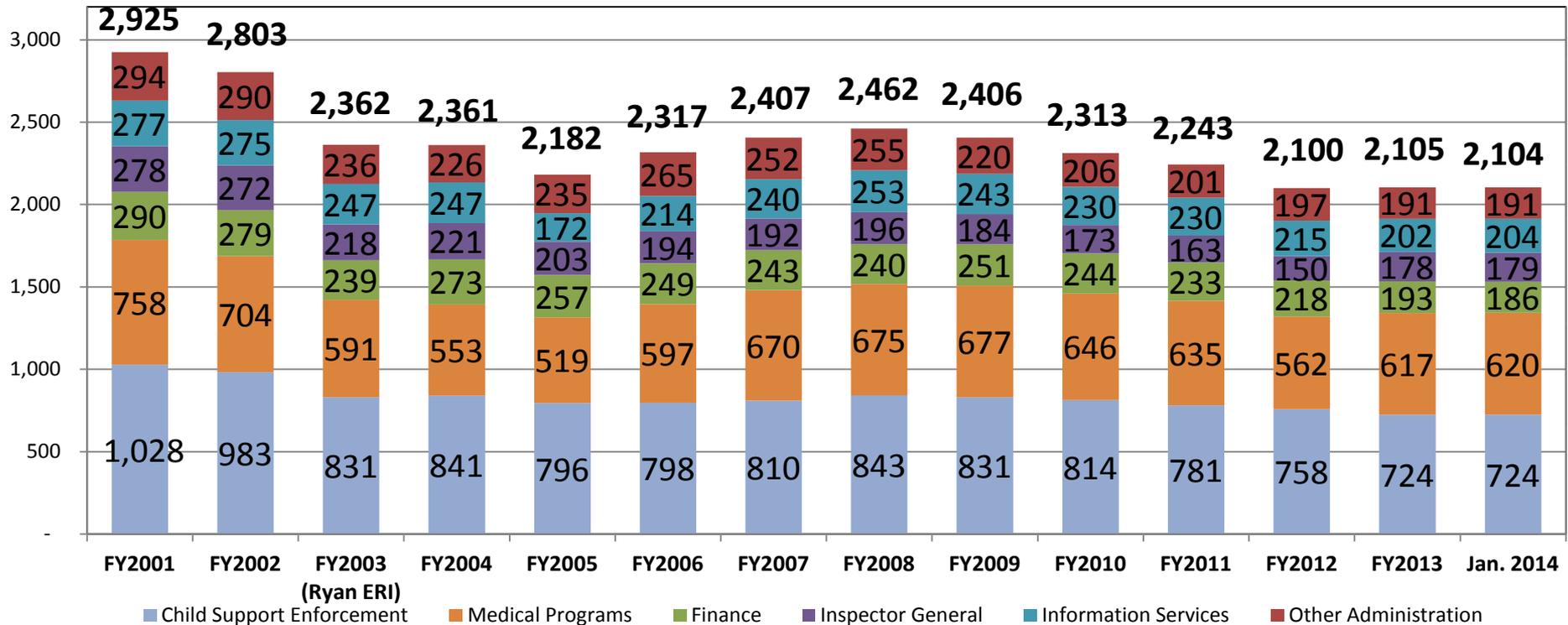
Total By Program	<u>All Funds*</u>		\$ Change
	<u>FY 2014</u>	<u>FY 2015</u>	
Medical Assistance	\$18,981.0	\$19,138.1	\$157.1
Child Support Services	212.7	259.6	46.9
Program Operations	297.6	268.7	(29.0)
Cost Recoveries	42.8	43.5	0.7
Inspector General	23.3	32.6	9.2
Total	<u>\$19,557.5</u>	<u>\$19,742.5</u>	<u>\$185.0</u>

General Revenue Fund*

Medical Assistance	\$6,965.8	\$7,039.0	\$73.2
Child Support Services	0.0	32.2	32.2
Program Operations	72.8	57.1	(15.6)
Inspector General	0.0	6.7	6.7
Total	<u>\$7,038.6</u>	<u>\$7,135.1</u>	<u>\$96.5</u>

* In FY2014, the General Assembly appropriated GRF Operations, including the Inspector General and the Child Support fund deposit, from a lump sum appropriation which is reflected in Program Operations. The FY2015 budget assumes operations costs are budgeted in the legacy appropriation lines.

Historical On-Board Headcount: Serving More Clients With Fewer Employees



HFS on-board headcount has decreased by 28%, or 821 staff since FY 2001, while enrollment in medical programs has increased 90% (1.3 million clients) and cases for which the Division of Child Support Services receives collections has grown by 54% (75,800 cases)