ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

Fiscal Years 2012, 2013 and 2014

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ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

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To the Honorable Bruce Rauner, Governor

And Members of the General Assembly:

This report provides details on specific programs, participant numbers, and provider reimbursement. Information on Department of Healthcare and Family Services' ("HFS" or "the Department") Medical Assistance Programs for fiscal year 2014, the most recently completed fiscal year, and the two previous years is provided to allow for comparisons. Long term care-specific information is also contained for fiscal year 2014 in compliance with reporting requirements. The HFS Medical Assistance Program Annual Report consolidates the reporting requirements under Sections 5-5, 5-5.8, and 5/5.1-5-2 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 also contains updates on the Department's efforts in implementing Illinois' Medicaid Reform legislation *[P. A. 96-1501* and *P. A. 97-689],* the federal *Affordable Care Act [P.L. 111-148] and* progress toward the state law requirement to move at least 50% of Medicaid clients into care coordination. Each type of managed care and those included in their coverage are detailed in this report.

As of this writing, I am pleased to report that over 50% of Medicaid enrollees are now served through care coordination/managed care plans as required in the Medicaid Reform Law. I hope you find this report informative and useful as we work together to continue providing more accountable healthcare services, from both quality and fiscal perspectives, to Illinois' most vulnerable populations.

Sincerely,

Felicia F. Norwood, Director
Department of Healthcare and Family Services

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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 2014, Medicaid, and the medical programs associated with it, provided comprehensive health care coverage to approximately 3.2 million Illinoisans and partial benefits to 86,087 individuals.

The Department's programs currently cover approximately 3.2 million enrollees, including almost 1.6 million children, 191,000 seniors, 254,000 persons with disabilities, 1.1 million non-disabled, non-senior adults and 67,000 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 significant shift in the numbers of those included in various coverage groups due to the Affordable Care Act.

Comprehensive Benefits	**FY2012**	**FY2013**	**FY2014**
Children	1,697,175	1,647,423	1,572,532
Disabled Adults	266,664	266,419	254,393
Other Adults	647,451	713,402	1,124,106
Seniors	178,098	181,449	191,329
All Comprehensive	2,789,388	2,808,693	3,142,360
All Partial Benefits	269,336	86,087	67,706
Grand Total All Enrollees	**3,058,724**	**2,894,780**	**3,210,066**

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 2014, the Department spent approximately $16 billion (all funds), of which $10.49 billion was GRF/GRF like funds, on enrollee health benefits and related services. These individuals were served by approximately 84,199 providers of medical services, including 47,764 physicians, 2,887 pharmacies, 446 home health agencies, 243 hospitals and 831 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)*, continued to be the centerpiece of the Department's Medicaid reform efforts in FY14. As such, the transition from a fee-for-service system to a more integrated healthcare delivery system continued to require major changes for the provider community and clients and will continue into reporting period 2015. 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 proceeded with implementing several of its Care Coordination initiatives during 2014.

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 (4) types of entities:

- Managed Care Organizations (MCOs), which are traditional insurance-based companies accepting full-risk capitated payments;
- Managed Care Community Networks (MCCNs), which are provider-organized entities accepting partial-risk or full-risk capitated payments;
- Care Coordination Entities (CCEs), 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 Special Needs and Seniors and Persons with Disabilities); and
- Accountable Care Entities (ACEs), which are provider-organized entities on a three-year path to full-risk capitated payments.

Programs that were implemented during 2014 as part of the Department's Care Coordination initiatives include the following:

January, 2014

- ◊ Affordable Care Act (ACA) Adults: The Department initiated enrollment of these adults into the Primary Care Case Management program in most counties throughout the state. In June and July of 2014 most ACA adults began to transition to the mandatory managed care plans in order to be in alignment with the Illinois Medicaid reform law.
- ◊ The Department continued its work with nine (9) ACEs to develop contracts and establish care coordination models in order to begin enrollment of the family health plan and ACA adults in July 2014 in the Central Illinois region, and expanded into the other four (4) mandatory managed care regions shortly thereafter.

February, 2014

- ◊ Began enrollment of approximately 80,000 Seniors and Persons with Disabilities in the city of Chicago into the Integrated Care Program and CCEs. Depending on the location of the client, the expansion offered most individuals a choice between several MCOs and CCEs for their care coordination needs.
- ◊ Began enrollment into the Medicare-Medicaid Alignment Initiative demonstration for approximately 136,000 individuals with dual-eligibility (Medicare/Medicaid) under dual-capitation in the Central Illinois and Greater Chicago regions. The first effective date for enrollment into the MMAI program, through voluntary choice, was March 1, 2014. The first effective date for passive enrollment into the MMAI program was June 1, 2014. Individuals in the Greater Chicago area have up to six (6) MCOs to select from and individuals in the Central Illinois region have two (2) MCOs to select from for their plan.

July, 2014

- ◊ Began mandatory enrollment of the Family Health Population and the newly eligible ACA adults, approximately 1.8 million individuals, into a care coordination system in the mandatory regions. Under this expansion effort, individuals enrolled in the Illinois Health Connect program or with a Voluntary Managed Care Organization, and newly eligible ACA adults, started the process of enrolling with an MCO or ACE for their health care. Due to the volume of individuals who were

selecting a plan under this expansion, the enrollment choice period was implemented over a period of several months, continuing into early 2015.

August, 2014

◊ Began enrollment of Children with Special Needs into care coordination. Depending on the location of the client, the expansion offered most individuals a choice between several MCOs, ACEs and CCEs for their care coordination needs.

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, 2015, there were 107,407 clients enrolled in 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 (4) 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, 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 enrollee. ICP was phased in as two (2) service packages. 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 ICP can be found in Section VIII, Care Management, of this report and on the Integrated Care Program page on the Department's website.

B. Care Coordination Innovations Project

Illinois' Care Coordination goal 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 these efforts in early 2012 with the release of a solicitation seeking qualified and financially sound CCEs and MCCNs to coordinate care for Seniors and Persons with Disabilities. In addition, in December 2012, the Department issued a second solicitation seeking CCEs to serve Children with Special Needs. Both solicitations fulfilled a goal to allow providers to design and offer care coordination models other than traditional MCOs.

C. Medicare-Medicaid Alignment Initiative

The Medicare-Medicaid Alignment Initiative (MMAI) demonstration integrates services covered in Medicare and Medicaid under one managed care program and combines financing streams to eliminate conflicting incentives between the two (2) programs. The overarching goal of MMAI is to integrate benefits to create a unified delivery system that is easier for beneficiaries eligible for both Medicare and Medicaid (known as "dual eligibles") to navigate. HFS and federal Centers for Medicare and Medicaid Services (CMS) contracted with eight (8) MCOs (six in the Greater Chicago area and two in the Central Illinois region) to assume financial risk for the care delivered to dual eligible beneficiaries with responsibilities for robust care coordination efforts where performance will be measured and tied to quality measurement goals.

The Department received approval from CMS to jointly implement MMAI in early 2013 by reaching an 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 becoming effective March 2014. The contracts are for three (3) demonstration years, through December 2017.

D. Accountable Care Entities

An Accountable Care Entity (ACE) is a new model of an integrated delivery system created under SB26, passed by the General Assembly in May 2013, and signed into law on July 22, 2013 (Public Act 98-104). This is a fourth model providing care coordination services for Medicaid clients, and includes the following elements: (1) organized by providers to coordinate a network of Medicaid services; (2) enroll children and their family members, with an option to enroll newly eligible adults under ACA; (3) large enough to have an impact for a population: at least 40,000 clients in Cook County, 20,000 in collar counties, 10,000 downstate; (4) includes at a minimum the following types of providers: primary care, specialty care, hospitals, and behavioral healthcare; (5) has a governance structure that includes each type of provider; (6) has 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) are on a three (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 the first eighteen (18) months, partial risk after eighteen (18) months, and full risk after three (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 (5) months from the release of the Solicitation. The Department received eleven (11) proposals and entered into contracts with nine (9) of the entities. Enrollment of the Family Health Population and ACA adults into ACEs began in August 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 2014 INITIATIVES

A. Integrated Eligibility System (IES)

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 estimates completion of 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

B. 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. An extension to the original APD is being sought since federal CMS has extended the Go-Live timeframe to the end of 2015.

- Illinois has developed 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 Fiscal Year 2015.

C. New Medicaid Management Information System (MMIS)

The Department currently manages and operates its MMIS that supports management of client eligibility, provider enrollment, and medical claim processing. The existing MMIS was fully implemented in 1982 and was primarily built to support a fee-for-service Medicaid program. Even though many enhancements have been made to the current MMIS, it is a legacy system that is becoming increasing more challenging to maintain. Thus the reason for replacing the current MMIS with a more modern, state of the art system that will allow for more users controlled configuration and an opportunity to eliminate outdated business practices.

The Department developed a three prong approach to replacing its MMIS. First the department procured a vendor to assist with the planning activities of the project and to perform Independent Verification, and Validation (IV&V) that insures the department is delivered a system that meets its specifications. Second, the department procured a vendor to deliver a new pharmacy benefits management system. And third, the department is collaborating with the State of Michigan to share its MMIS via a cloud-based deployment.

Core MMIS. Through an intergovernmental agreement with the Michigan Department of Community Health, HFS will begin stages to use the State of Michigan's MMIS. The project to complete the work effort has been named the Illinois Michigan Program Alliance for Core Technology (IMPACT). The IMPACT project is a three phase initiative that delivers 1) a system (e-MIPP) to support the Electronic Health Record/Provider Incentive Payment (EHR/PIP) program, 2) a system to support provider enrollment, and 3) full implementation of a cloud enabled MMIS over several years.

All remediation activities for the Electronic Medicaid Incentive Payment Program system (e-MIPP) have been completed. Initial implementation occurred November 15, 2013.

Fit/Gap sessions for the Provider Enrollment system initially took place in July 2013. Further work was suspended to develop a mutually agreed upon project governance structure, a comprehensive statement of work, and until a project schedule was completed. Additional Fit/Gap sessions were resumed in September 2014. Detailed system design documents have been constructed and are currently under review. The Provider Enrollment System is expected to go-live late July 2015.

The start up of all activities related to full implementation of the cloud enabled MMIS will begin early 2015.

D. New Pharmacy System

HFS is working with the awarded vendor, Goold Health Systems (GHS), to implement its new Pharmacy Benefits Management System (PBMS). The PBMS will provide an Internet-based capability to interact with providers, manufacturers, HFS staff, and other stakeholders to conduct the business processes of managing the Pharmacy Services and Drug Rebate programs. This project is being implemented in two phases. Phase 1 will automate Drug Rebate processing including invoicing manufacturers to collect rebates for paid pharmacy claims. The majority of Phase 2 will implement Point-of-Sale functions which include adjudicating pharmacy claims submitted real-time and batch, handling drug prior approval requests; create a provider portal specifically for pharmacy services; e-Prescribing and clinical management; and Supplemental Rebate solution. While the PBMS will replace the pharmacy-specific functionality of the current Medicaid Management Information System (MMIS), it must interact with components of the existing MMIS.

To date, Joint Application Development (JAD) sessions for Phase 1 components is complete. The testing for Phase 1 is just beginning with an anticipated go-live date of January 1, 2015.

Phase 2 JAD sessions have been conducted. As a result of lessons learned during Phase 1 analysis, additional requirements gathering sessions are planned for December 2014. HFS and GHS are working together to determine a realistic go-live date which is anticipated to be late summer or early fall of 2015. This implementation will require extensive planning and coordination with the pharmacy and provider community to ensure minimal disruption of service for the agency's clients.

While GHS has successfully implemented its system in other states, Illinois is by far the largest Medicaid population of any state using this system. Additionally, GHS has been the fiscal agent handling all pharmacy processes for the other states. Illinois is the first state to purchase GHS' system as a Software as a Service (SaaS) model which means HFS staff will continue to administer the processes necessary to operate its pharmacy program, but will use the GHS deployed system either instead of or in conjunction with the HFS MMIS. The SaaS model requires a change of mindset for both HFS and the vendor so, by implementing this project via a two-phased approach, any issues related to the SaaS model should become apparent with implementation of Phase 1 so client services are not negatively impacted with the implementation of Phase 2.

E. New Web Based Application to Update or Change Enrollment Information for Currently Enrolled Providers

In December 2014, the Department implemented a new on-line application which allows currently enrolled medical assistance providers to make changes and updates to their enrollment information. The online application provides an efficient and convenient way for providers to revise information pertaining to the following categories:

- National Provider Identifier (NPI)
- Provider name
- Provider demographic (address, phone, email)
- Payee demographic (address, phone, email)
- Add a payee
- Close a payee
- Close enrollment
- License
- Clinical Laboratory Improvements Amendments (CLIA)

F. Hospital System Reimbursement Design

On July 1, 2014, the Department implemented new hospital inpatient and outpatient reimbursement systems following two and a half years of working alongside the hospital community to agree on new payment concepts and methodologies. The 20 year old CMS-DRG inpatient system was updated to the latest APR-DRG system which greatly expanded the diagnosis related groupings from roughly 400 to over 12,000. This alone allows for more accurate payment based on the acuity of the services provided. Funding that historically was paid in out-of-control outlier payments were incorporated into the base rates and the hospital cost-to-charge ratios are now updated to bring outlier payments closer

to the industry norm. In addition, the Department created policy adjustors or, payment enhancers, to the base reimbursement for trauma services provided at trauma level 1 and 2 hospitals, perinatal services provided at perinatal level 3 hospitals, transplantation services, and to account for graduate medical education at academic medical centers and major teaching hospitals. Additional add-on payments were created to supplement safety net hospital and some psychiatric inpatient reimbursement.

The 15 year old APL outpatient system was updated with the latest EAPG system, expanding payable groupings from 16 to over 500. This allows for payment of multiple services provided in the same visit and for much more precise payment for the services provided. To offset historic inequities between the inpatient and outpatient rates of reimbursement and to further incentivize the use of the outpatient setting, the Department shifted $155 million of historical inpatient funding to the outpatient rates. In addition, policy adjustors were applied to enhance payment to regional and statewide outpatient high volume and safety net providers.

While the Department eliminated most of the $420 million dollars of GRF funded static payment programs, over $330 million of GRF static payments remain. However, over $290 million of transition payments were created to mitigate any hospital specific projected overall reductions in payment due to the new reimbursement systems ($200 million of that was pulled out of the base reimbursement rates and the other $90 million was additional funding). The transition payments are set to be in place for four years, after which the Department, working with the hospital industry advisory group, will look into targeting a portion of those dollars into base reimbursement rates or policy adjustors.

G. 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, Division of Developmental Disabilities, and the Illinois Housing Development Authority on the formation of policy and implementation issues related to MFP.
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 and ongoing through 2014. 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. 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 project which continued operations in calendar year 2013. The Department expanded the ADRC initiative to include Kane, Lake, Will, Madison and St. Clair Counties in calendar year 2014. The initiative is currently entirely funded by MFP rebalancing funds.

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**.** In addition to funding the ADRC pilot, 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. In 2014, the Department utilized Balancing Incentive Payment Program (BIP) and MFP rebalancing funds to continue to expand DMH expansion to numerous other counties, bringing the total number of DMH/MFP counties to ten including Cook County.

The Department continued to rely on the MFP website and web referral form to provide program information and generate program referrals in 2014. The website was created in collaboration with our state agency partners and stakeholders and includes MFP marketing and outreach materials <www.mfp.illinois.gov>. In September 2014, the Department updated the MFP web application to a Microsoft Customer Relationship Management application, bringing modern and secure cloud based technology to the MFP program. The new CRM web app couples the web referral system with the MFP case management and quality assurance system, allowing automated program referrals and seamless reporting capabilities.

During calendar year 2014, the MFP Program completed a total of 604 successful transitions, an increase of 277 transitions over the calendar year 2013. The MFP Program completed 1,707 cumulative transitions by the end of calendar year 2014. The Department anticipates growth in the number of transitions for calendar year 2015 due to a number of factors including: Efforts by the Department to conduct direct outreach and generate additional MFP program web referrals

- The initiation of a MFP/Managed Care collaborative model that incentivizes or rewards MFP community providers for sustaining individuals in the community post transition and thereby avoids re-institutionalization
- The ongoing implementation of two Olmstead related class action lawsuits – *Ligas v. Quinn* and *Colbert v. Quinn*;
- The MFP/ADRC collaboration;
- The continued expansion of MFP/mental health;
- The continued participation of the DHS Division of Developmental Disabilities in MFP.

Calendar Year 2014 MFP Transitions

Population Group	# Transitions
Individuals who are Elderly	36
Individuals with a Physical Disability	47
Individuals with a Serious Mental Illness	41
Individuals with an Intellectual Disability	111
Colbert Class Members (cross population)	369
Total	604

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%
2014	$4,756,731,217	$2,047,212,673	43.07%

*Table does not reflect services received in a given year. Expenditures are reported for all agencies as reflected in the CMS-64 quarterly claim totals as submitted to Federal CMS. Fiscal year totals include adjustments made for services received in previous years.

H. Balancing Incentive Program

The federal Balancing Incentive Program (BIP), authorized by the Affordable Care Act, incentivizes States to increase access to non-institutionally based Long-Term Services and Supports (LTSS). Under the BIP, the federal Centers for Medicare & Medicaid Services (CMS) requires States to implement three structural reforms to their LTSS system in exchange for a two percent increase in their Federal Medicaid Assistance Percentage (FMAP). The three structural reforms include the

implementation of: No Wrong Door/Coordinated Entry Point; the provision of Conflict Free Case Management services; and implementation of a Core Standardized Assessment tool. Illinois anticipates receiving $90.3 M over the course of the BIP – through September 30, 2015.

As of September, 2014 Illinois had drawn down approximately $46 M in enhanced FMAP. Illinois is reinvesting the BIP funding towards our continued efforts to rebalance the State's LTSS system. Most of the funding initiatives were developed as a result of the lessons learned through the implementation of the Money Follows the Person Program and the State's other rebalancing initiatives including implementation of three Olmstead Consent Decrees and closure of state facilities.

The Administration, in collaboration with State Agencies, recently selected a vendor for the implementation of a core standardized assessment tool. FEi Systems will assist the State with the implementation of a Uniform Assessment tool (UAT). The Department of Healthcare & Family Services, the Department on Aging, the Department of Human Services, along with external stakeholders, developed a protocol for the implementation of conflict free case management. The State also developed an Communications Plan for the implementation of the No Wrong Door (NWD) structural requirement. HFS recently procured the assistance of a vendor for the implementation of the Communications/Marketing of the NWD.

IV. LONG TERM CARE

The monthly average of people served in nursing facilities (NFs) during fiscal year 2014 has remained around 56,000. The number of facilities serving these people decreased slightly in 2014 (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 2012 through 2014. 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 104,500 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 Program (SLP) participants receive services that are provided in compliance with state and federal rules. In addition SLP reviews ensure providers that are developing their programs 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 SLP providers which include investigations of complaints received through the SLP Complaint Hotline, annual recertification and critical incident monitoring. NF reviews consisted of conducting rate review protocols and methodologies. Residents receiving enhanced 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 2014, six nursing facilities (NFs) and eleven Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) voluntarily closed. Of the eleven ICD/IIDs that closed ten converted to Community Integrated Living Arrangements (CILAs). All residents were relocated to appropriate settings. The remaining ten facilities (three NFs and seven ICF/IIDs) closed voluntarily. Two 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.

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 4,024,754 assessments for 432,465 residents. For fiscal year 2014, the system received and processed 1,087,992 new records, including admissions, quarterly updates, change of status, and discharge records for 193,876 unique individuals.

Improving LTC Application Timeliness: As a result of PA 98-014, HFS and DHS implemented a project to review the timeliness of medical applications for LTC. PA 98-0104, has three basic requirements with regard to Long Term Care (LTC) eligibility determination:

- *Complete LTC eligibility determinations in a timely manner.*

  In response to this, DHS has substantially reorganized its process for approaching Long Term Care (LTC) case processing into two LTC hubs using specifically trained caseworkers to handle LTC processing of applications, redeterminations and changes. Second, DHS and HFS have created a data base of pending LTC applications. This combination of efforts and extraordinary effort by DHS

management and staff has allowed the number of pending applications to fall from over 10,000 in January of 2014 to 2,200 in February of 2015. Cases pending with the HFS Office of Inspector General for resource review have dropped from almost 2,200 in January of 2014 to 600 in February 2015. Applications pending more than 90 days have decreased from almost 6,000 in January 2014 to less than 900 in February 2015.

- *Assess feasibility of incorporating all information needed to determine eligibility for long-term care services, including asset transfer and spousal impoverishment, into the State's integrated eligibility system.*

  The State is exploring both the technical and budgetary feasibility of incorporating more information into the online application system and working with the Integrated Eligibility System (IES) team to identify every opportunity to add increased usability for LTC applicants. In the interim, the IES already includes a feature in the application (known as ABE—Application for Benefit Eligibility) that allows uploading of scanned documents and a number of trainings have been done for LTC providers in using the ABE system to assist LTC applicants to apply. Current IES development is focused on the expansion of IES to handle case maintenance in the fall of 2015 and additional changes may have to wait until the IES testing of current planned expansion has proven successful.

- *Develop and implement a stream-lined LTC application process.*

  DHS and HFS representatives meet regularly with representatives of the LTC industry to identify ways to stream-line the application process. Both DHS LTC hubs held informational sessions in early 2015 to allow LTC providers to ask questions and get first-hand information. Training sessions on using the ABE application system were presented in-person and videotaped for use as webinars on the HFS website. The state is incorporating every electronic source currently available into the IES system to minimize the amount of information required to be provided by the client to prove eligibility. Some information is not available from current electronic sources and must be requested from the applicant.

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 state Medicaid agency, provides direction, oversight, program monitoring, fiscal monitoring, and administrative coordination to secure federal funding.

The programs operated by sister agencies are the HCBS waivers for: 1) Persons with HIV/AIDS; 2) Persons with Brain Injury; 3) Persons with Disabilities; 4) Adults with Developmental Disabilities; 5) Children and Young Adults with Developmental Disabilities-Support; 6) Children and Young Adults with Developmental Disabilities-Residential, all of which are operated by the Department of Human Services; 7) Persons who are Elderly, operated by the Department on Aging; and 8) Medically Fragile Technology Dependent (MFTD) Children, 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 2013, 114,381persons were served in HCBS waivers. The growth history of the waiver program from waiver year 2007 through 2013 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 LAG	105,315	$1,546,410,363
WY 2013 Initial		$1,516,870,482

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.

In Fiscal Year 2014, the waivers for Persons who are Elderly and Persons with Disabilities were granted extensions, pending submission of renewal applications to federal CMS. For additional information on the HCBS waivers, please refer to Section II, Appendix B and Section XXII, Table VII of this report.

Fiscal year 2014 was an active year for our Illinois HCBS waivers. Amendments to most of our waivers were submitted relating to the ACA and to several of our waivers relating to the Integrated Care Program and MMAI demonstration. Federal CMS published new rules in March 2014 requiring states to ensure that individuals receiving Long Term Services and Supports have full access to the benefits of community living and the opportunity to receive these services in the most-integrated setting appropriate. These rules require Illinois to submit a Statewide Transition Plan that has included stakeholder input and begin a process in March 2015 to reach full compliance by March 2019. These federal rules relate to the residential setting for two of our waivers -- Residential Services for Children and Young Adults with Developmental Disabilities and Supportive Living Program and to non-residential settings for most of the other waivers pertaining to where and when a waiver participant goes to the setting to engage in the service. Information regarding the new federal HCBS settings requirements may be found on the Department's Statewide Transition Plan web page. For additional information on the HCBS waivers, please refer to Section V, Section XVII Appendix B and Section XIX, 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 January of 2014 Perinatal Report, the most recent report, is available on the Department's Web site 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 CY2010 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 2012 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 over 90 percent of teen deliveries in Illinois.

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%
2013	9,748	10,437	93.4%

*Less than 20 years of age
Source: HFS Enterprise Data Warehouse, 2014, Birth File Match. These data are provisional pending certification of CY2011-CY2012 Illinois Department of Public Health Vital Records. Covered Deliveries are those where the recipient had full benefits on date of delivery. The table was updated to reflect current data.

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 that uses evidence-based strategies; expanding birth intervals; access to smoking cessation; and access to 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 inter-pregnancy 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 PA 93-0536, the Department reports on the status of prenatal and perinatal healthcare services to the legislature every two years. The Perinatal Reports to the General Assembly from 2004 through 2014 are posted on the through is available on the HFS Web site. HFS initiatives focused on improving birth outcomes are described below.

Illinois Healthy Women (IHW)

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. A new federal healthcare law, known as the Affordable Care Act (ACA), requires all individuals to have minimum essential healthcare coverage, which includes birth control services. As a result, women enrolled in IHW will now have the opportunity to obtain comprehensive healthcare coverage through either Expanded Medicaid or the Health Insurance Marketplace. Therefore, to ensure a seamless transition into affordable healthcare plans, IHW continued to provide coverage through December 31, 2014 to allow a transitional year for IHW clients to obtain other healthcare coverage.

IHW was 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 for with State funds.

Since the inception of IHW in 2004 through August 2014, a total of 192,961 unduplicated women received services. During waiver year 9 (April 2012-March 2013), the average cost for a woman receiving a year of family planning services was approximately $315, while the average cost for prenatal care, delivery, postpartum care and the first year of the child's life was approximately $11,944. Using federal CMS' averted births methodology, during the first nine years of the waiver, it is estimated that 42,789 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 $391.7 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 Pregnancy Risk Assessment System (PRAMS) data, unintended pregnancies continued to show a downward trend throughout the first six years of the waiver.

Comprehensive Family Planning Services – Planned Pregnancies

After a decade of providing expanded family planning through the Illinois Healthy Women Program, which was phased out December 31, 2014, HFS took steps during 2014 to increase access to quality family planning services for women and men in the Medicaid Program by providing comprehensive and continuous coverage to ensure that every pregnancy is a planned pregnancy. In June, a notice to providers confirming the Department's commitment to quality family planning and reproductive health services was released, and in

August, the Family Planning Action Plan was announced. Additional information specific to this effort can be found on the Department's Family Planning and Birth Control web page.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

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. In late 2014, CMS offered the opportunity for CHIPRA grantee states to request no-cost extensions for up to one additional year. A one-year no-cost extension request has been approved by CMS and will allow the CHIPRA grant to continue through February 2016.

The CHIPRA Quality Demonstration Grant includes a focus on improving birth outcomes. A number of interventions have been developed, including a prenatal minimum electronic data set, a prenatal care quality tool, best practices for perinatal care transition, and a toolkit focused on educating women about preconception, prenatal, postpartum and interconception care. A postpartum care study is underway with the University of Illinois at Chicago and CHIPRA supported the creation of the Illinois Perinatal Quality Collaborative (ILPQC), a voluntary hospital-focused quality improvement collaborative that uses best practices and quality improvement science to improve the quality of perinatal care and birth outcomes for women and infants with focus on both obstetrical and neonatal care. Projects implemented in 2014 include reduction of early elective delivery and a Neonatal Intensive Care Unit (NICU) infant nutrition and feeding initiative.

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 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;
- The program should be available in areas of high need vs. statewide; and
- The program should recognize differences in Cook County and Downstate.

DHS executed 23 new Intensive Case Management (ICM) contracts mid-FY2013 as the initial step towards the redesign of the program.

During CY2013, HFS finalized the first phase of 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 (BBO) program.

The second phase of the algorithm was implemented late in CY2014. The algorithm was enhanced to include additional risk factors associated with poor birth outcomes. A woman is flagged as high-risk if she had any of the following:

1. Incompetent cervix claim;
2. Mental health claim (within a year of her first pregnancy related claim);

3. Drug/alcohol abuse claim (within a year of her first pregnancy related claim);
4. Obesity claim (within a year of her first pregnancy related claim);
5. Previous low/very low birth weight baby (based on birth outcome, birth weight, or diagnosis code);
6. Aged < 17 years as of her last pregnancy related claim;
7. Aged > 35 years as of her first pregnancy related claim ;
8. Previous high-cost Medicaid birth (the net liability for the baby's first year of claims was in the 99th percentile).

A third phase of the algorithm is planned to be implemented during CY2015. A phased approach to risk factor identification provides DHS the opportunity to test the results to assure the algorithm is accurately identifying women at risk.

Evaluation of the BBO program 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. During CY2014, HFS programmed the following measures to assess the BBO program:

1. Frequency of Ongoing Prenatal Care (HEDIS®);
2. Prenatal and Postpartum Care (HEDIS®) – two rates reported;
3. Perinatal Depression Screening (state specified measure).

DHS is in the process of reviewing these reports and will provide information to HFS about its findings.

Partnerships with Local Health Departments

Through agreements with 78 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 has partnered 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 have been 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. Most public-private projects have concluded and are being sustained through integration into ongoing activities articulated through the recent release of the revised *Handbook for Providers of Healthy Kids Services* released January 2015 (e.g., Bright Futures as a Standard of Care, obesity-related follow-up visits, Early Intervention referral systems), and as reported in the Perinatal Reports to the General Assembly.

Measuring Progress and Quality: Child and Adult Core Set Measures

The Children's Health Insurance Program Reauthorization Act (CHIPRA) established an initial core set of children's health quality measures. The initial core set was published in February 2011. CHIPRA required the Department of Health and Human Services (HHS) Secretary to publish annual changes to the Child Core Set beginning in January 2013. Following review, CMS periodically adds or retires measures from the core set. The current core set was used for FFY2014 reporting to the Centers for Medicare and Medicaid Services (CMS) (reporting due December 31, 2014). More information about the CHIPRA Initial Core Set of Children's Health Care Quality Measures Child Core Set is available at Medicaid.gov web site.

States voluntarily report to CMS via the CHIP Annual Reporting Template System (CARTS). However, Illinois is required to report the 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 FFY2010. At that time, 10 measures were reported. In FFY2012, Illinois reported on 20 measures. In FFY2013, Illinois reported 25 of the 26 measures. During FFY2014, 21 of 23 measures were reported.

The 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 CAHPS was conducted during 2013/2014. Due to timing and significant changes to the healthcare delivery system resulting from care coordination efforts, the CAHPS survey was not implemented during CY2014 for FFY2014 reporting.

The July 2014 Child Core Set measures with the FFY2014 reporting status of each measure to federal CMS is identified in the chart below and continues to the next page.

	Measure	**Status FFY2014**
PPC	Timeliness of Prenatal Care	Reported
FPC	Frequency of Ongoing Prenatal Care	Reported
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 those Eligible who 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	Retired by CMS July 2014
	Otitis Media with Effusion (OME) – Avoidance of Inappropriate Use of Systemic Antimicrobials	Retired by CMS May 2013
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	Retired by CMS July 2014

ADD	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Reported
PA1C	Annual Pediatric Hemoglobin (HbA1c) Testing	Retired by CMS July 2014
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	Not reported for FFY2014; received a deferral to FFY2015
HPV	Human Papillomavirus Vaccine for Female Adolescents	Reported
BHRA	Behavioral Health Risk Assessment (For Pregnant Women)	Not reported – E-specified measure, data not available
MMA	Medication Management for People with Asthma	Reported

The CHIPRA grant allowed HFS to test data collection and reporting of the CHIPRA Child Core Set. For additional information on the child core set data reported by the Department, refer to the 2014 CHIP Annual Report available on the Department's Reports web page.

This report includes Title XIX and Title XXI groups. The entire HFS enrolled population (Title XIX, Title XXI and state-only funded) child core set data (FFY2013) are included in the Child Core Set Data Book, also available on the Reports web page. For more information on the CHIPRA Grant refer to Section XVIII, Quality Assurance, Utilization and Control, of this report.

At the national level, state progress on reporting the Child Core Set measures is included in the most recent Secretary's Annual Report on the Quality of Care for Children in Medicaid and CHIP found on the Medicaid.gov web site.

Parallel to the Child Core Set measures and processes, the *Affordable Care Act (Section 1139B)* requires the HHS Secretary to identify and publish a core set of quality measures for adult Medicaid enrollees. Like the Child Core Set, the Adult Core Set measures are updated annually by CMS. States voluntarily report progress on measures into CARTS, and a Secretary's report is published annually identifying state progress on reporting. Information about the Adult Health Care Quality Measures and the Secretary's Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid can also be found on the Medicaid.gov web site.

HFS first reported a sub-set of Adult Core Set measures to CMS via CARTS for FFY2013 (report submitted December 2013). At that time, seven of 26 total measures were reported. The FFY2014 Adult Core Measures Report was submitted to CMS in January 2015 based on core set specifications dated May 2014. Fourteen of the 26 Adult Core Set measures (including one developmental measure on contraception use) were reported to CMS.

The table that follows below, and continues on the next page, lists each measure in the May 2014 Adult Core Set and whether it was reported to CMS.

	Measure	**Status FFY2014**
FVA	Flu Vaccinations for Adults Ages 18 to 64	Not reported - CAHPS data not available
ABA	Adult Body Mass Index (BMI) Assessment	Reported
BCS	Breast Cancer Screening	Reported
CCS	Cervical Cancer Screening	Reported

MCS	Medical Assistance with Smoking and Tobacco Use Cessation	Not reported – CAHPS data not available
CDF	Screening for Clinical Depression and Follow-up Plan	Not reported – requires medical record review
PCR	Plan All-cause Readmission Rate	Not reported
PQI01	Diabetes Short-term Complications Admission Rate	Reported
PQI05	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	Reported
PQI08	Congestive Heart Failure (CHF) Admission Rate	Reported
PQI15	Adult Asthma Admission Rate	Reported
CHL	Chlamydia Screening Women Ages 21 to 24	Reported
FUH	Follow-up After Hospitalization for Mental Illness	Reported
PC01	Elective Delivery	Not reported – requires medical record review
PC03	Antenatal Steroids	Not reported – requires medical record review
HVL	HIV Viral Load Suppression	Not reported – LOINC data not available
CBP	Controlling High Blood Pressure	Not reported – requires medical record review
LDL	Comprehensive Diabetes Care - LDL-C Screening	Reported
HA1C	Comprehensive Diabetes Care - Hemoglobin A1c Testing	Reported
AMM	Antidepressant Medication Management	Reported
SAA	Adherence to Antipsychotics for Individuals with Schizophrenia	Not reported
MPM	Annual Monitoring for Patients on Persistent Medications	Not reported
CPA	CAHPS Health Plan Survey 5.0H - Adult Questionnaire	Not reported – survey not conducted
CTR	Care Transition - Transition Record Transmitted to Health Care Professional	Not reported – E-specified measure, data not available
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Not reported
PPC	Postpartum Care Rate	Reported
Developmental measure	Contraception Utilization	Reported

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 website, 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 preventative, diagnostic, and restorative services. On June 16, 2014, the Governor signed Public Act 98-0651, into law which restored adult dental services effective July 1, 2014. Adult dental benefits were restored back to the pre-SMART Act levels. Additionally, pregnant women (prior to the birth of their children) are now eligible for the additional following five preventive dental services:

- D0120 – Preiodic Oral Evaluation
- D1110 – Cleaning
- D4341 – Periodontal Scaling and Root Planning – 4 or more teeth per quadrant (deep cleaning)
- D4342 – Periodontal Scaling and Root Planning – 1-3 teeth per quadrant (deep cleaning)
- D4355 – Full Mouth Debridement (gross removal of plaque and calculus)

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 HEDIS Annual Dental Visit results for the 2014 calendar year. The Annual Dental Visit HEDIS measurement shows that 57.4 percent of beneficiaries between 2 and 20 years of age, eligible for services, had at least one dental visit during the reporting period.

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. In 2012, 14 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 preventative 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 an oral examination, prophylaxis (cleaning), 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 on the Bright Smiles from Birth Web site. 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 2013, 27,478 unduplicated children under the age of three received fluoride varnish application in a pediatric practice.

Reimbursement

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

During fiscal year 2014, payment for dental care totaled over $228 million. DentaQuest reported that 885,170 individuals under the age of 21 received almost 7 million dental services, for a total expenditure of approximately $ 235 million. For the same time period, 53,583 individuals ages 21 and over received over 250,000 emergency dental services for a total expenditure of approximately $6.7 million.

More information regarding the HFS Dental Program may be obtained on the Department's Dental Program web page or visit DentaQuest or call 1-888-286-2447 for help finding a dentist.

VIII. CARE MANAGEMENT

In 2014, the Illinois Managed Care program was expanded to include the Innovations Program for Seniors and Persons with Disabilities, Program for Children with Special Needs (CSN CCEs), the Medicare-Medicaid Alignment Initiative (MMAI) demonstration, and Accountable Care Entities (ACEs), in addition to building upon traditional delivery systems such as the Integrated Care Program (ICP) and expansion of managed care programs for the Family Health Plan (FHP) population and Affordable Care Act (ACA) Adults in 2015. Each of these programs provides medical homes for their enrollees. These additional managed care models are critical to meet the Department's goal of testing innovative care coordination models.

Integrated Care Program

The Department implemented 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 2010 to integrate and manage the care of the nearly 35,000 SPDs who lived in suburban Cook, DuPage, Kane, Kankakee, Lake and Will counties and were enrolled in ICP. ICP was expanded to four (4) additional regions in 2013 and three (3) other health plans in 2014. 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 2013. The Department contracted with Molina, Meridian and Health Alliance Connect 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 2013. The Metro East region, consisting of Madison, St. Clair and Clinton counties, also went live in September 2013 and is covered by Molina and Meridian. IlliniCare operates in the Quad Cities region (Rock Island, Mercer and Henry counties) which was added in November 2013. BlueCross BlueShield, Cigna-HealthSpring and Humana began serving the Greater Chicago region in March 2014. Lastly, CountyCare (supported by Cook County Health and Hospitals System) began serving SPD members in Cook County under their Family Health Plan (FHP)/Affordable Care Act (ACA) contract that became effective July 1, 2014.

ICP Services

Service Package I of 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 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 (HCBS) 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 HCBS 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 (3) 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 ICP was designed to empower members to be in control of their own health care.

Performance Measures

The contracts with Aetna Better Health, BlueCross BlueShield, Cigna-HealthSpring, Community Care Alliance of Illinois, CountyCare, Health Alliance Connect, Humana, Illinicare, Meridian and Molina contain thirty-five (35) performance measures that create an incentive for the 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 thirty (30) days after receiving a mental health diagnosis, follow up with a provider within fourteen (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 Illinois Health Connect (IHC) Program focuses on the promotion of the patient-physician relationship in order to improve the quality of healthcare for members, support continuity of care initiatives, improve access to care, and reduce unnecessary emergency room visits and hospitalizations through established medical homes. The Primary Care Case Management (PCCM) program was the Department's first step toward implementing managed care throughout the state. Currently, Illinois is in the midst of increasing its healthcare delivery systems to ensure it is more patient-centered, with focus on improved health outcomes, enhanced patient access, and patient safety. These efforts include expanding the current healthcare delivery system to assist the state in meeting the Medicaid reform law under P.A. 96-1501 and Affordable Care Act (ACA) initiatives.

To meet these goals, upwards of 1.5 million people on Medicaid and All Kids in five (5) mandatory managed care regions, including those individuals currently enrolled in IHC, will be moved into some form of care coordination with a managed care health plan. This means that during the reporting period for 2015, the majority of clients currently enrolled in IHC will join managed care health plans for their care coordination services. IHC will continue to be a choice for clients in the non-mandatory managed care regions; however, it will no longer be a statewide Health Plan Choice for clients. IHC will also provide some program support for the Care Coordination Entities (CCEs) and ACEs.

As of June 30, 2014, there were over 2.0 million Medicaid enrollees who had either chosen or been assigned to a Primary Care Provider (PCP) for their medical home. Of these, over 1.7 million enrollees were enrolled with a PCP in IHC for their medical home. In addition, as of June 30, 2014, IHC had enrolled over 5,600 medical homes, which includes Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) enrolled sites. The enrolled medical homes provided a panel capacity of over 5.3 million patients, greatly exceeding the capacity required for all eligible clients statewide.

During 2014, IHC continued to assist clients with outreach and education strategies to help them better understand the importance of working with their PCP, how to access care, and the importance of health and wellness. An example of an IHC 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 FY14, the EPSDT outreach initiatives resulted in over 1.2 million Healthy Kids and Adult Preventive Notices mailed. In addition, IHC made almost 470,000 outreach and education calls to remind clients that primary and preventive services may be due based on HFS claims data and assisted clients in making an appointment with their PCP to receive the needed services. Through these initiatives, clients increased access to care, are connecting with their

medical homes, and are receiving needed medical services in the most appropriate setting, their PCP's office.

Quality Initiatives

During 2014, IHC's quality assurance program continued to focus on quality improvement efforts and best practices in the administrative practices and clinical functions of IHC. This quality improvement program includes strategies to assure access to care, evaluate provider and client education, and 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 ensure that enrollees are receiving quality healthcare services. In order to assist PCPs in improving the quality of care for their enrollees, IHC continues to provide quality tools to PCPs for use in coordinating and providing care for their enrollees, including:

- *Panel Rosters* – The IHC Panel Roster is a listing of all the patients who 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 Medical Electronic Data Interchange (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 IHC 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 IHC 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 IHC to direct enrollees and PCPs to the most appropriate specialist provider.

In addition, during FY14, IHC's Provider Service Representatives and Quality Assurance Nurses in the field made over 1,000 visits to providers' offices each month to assist with billing/coding questions, program administration, EPSDT standards, quality improvements efforts and to provide MEDI training.

Additional information about IHC can be found at: www.illinoishealthconnect.com

Voluntary Managed Care

The Voluntary Managed Care program was a healthcare option for Medical Assistance Program participants in Illinois from 1976 through June 30, 2014, even with the implementation of the PCCM program. MCO enrollment only increased 2 percent during FY 2014, from 245,015 participants at the beginning of the fiscal year (July 1, 2013) to 250,054 at the end of the fiscal year (June 30, 2014). The Voluntary Managed Care program contracts ended June 30, 2014 and the participants were covered under the mandatory Family Health Plan (FHP)/Affordable Care Act (ACA) program effective July 1, 2014.

The Voluntary Managed Care program was 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 had the choice to opt out of IHC and select an MCO as their medical home. MCOs included 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 HFS as meeting requirements established by HFS for such organizations.

The Department contracted 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 were the same. These MCOs offered the same comprehensive set of services to their enrollees, as were 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 were not covered under the MCO contract, MCO enrollees were able to 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 were contractually required to provide case management and disease management services to members with specific diagnosis or who required high cost and/or extensive services. The MCO contract specified the parameters of the MCO's case management and disease management programs and systems. The MCOs were required to submit their case management and disease management policy/plan and report monthly on these programs, which were reviewed and monitored by HFS and the contracted External Quality Review Organization (EQRO). Additionally, the EQRO provided technical assistance to HFS and the MCOs as well as oversight and monitoring of the quality assurance components of the MCO contract, including each MCO's case and disease management systems.

Medicare-Medicaid Alignment Initiative

On February 22, 2013, the Department received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the Medicare-Medicaid Alignment Initiative (MMAI). MMAI is a groundbreaking joint effort to reform the way care is delivered to clients aged twenty-one (21) and over who are eligible for both Medicare and Medicaid Services (called "dual eligibles"). The MMAI demonstration project was anticipated to provide coordinated care to 148,000 Medicare-Medicaid enrollees in the Chicagoland area and 20,000 enrollees throughout central Illinois beginning in early 2014. MMAI is a voluntary program with passive enrollment. MMAI became effective March 1, 2014 and is a three (3)-party contract between HFS, CMS and eight (8) MCOs: Aetna Better Health, BlueCross BlueShield, Cigna-HealthSpring, Health Alliance Connect, Humana, IlliniCare, Meridian and Molina. MMAI operates in the Greater Chicago region (Lake, Kane, DuPage, Cook, Will and Kankakee counties) and Central Illinois region (Knox, Stark, Peoria, Tazewell, Menard, Logan, Sangamon, Christian, McLean, DeWitt, Macon, Piatt, Ford, Champaign and Vermilion counties). Health Alliance Connect and Molina are the only MCOs covering the Central Illinois region and not the Greater Chicago region. Enrollment was 71,577 members as of January 1, 2015.

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

In 2014 the Department implemented five (5) SPD CCE health plans based on their demonstrated ability to offer a holistic approach to delivering coordinated care for special populations, including seniors and adults with disabilities. Each entity has the capacity to 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 (5) SPD CCEs was implemented in September 2013 and the other four (4) CCEs were implemented from October 2013 through February 2014. All CCEs implemented in 2014 received enrollment in the 2014 reporting period.

The Department recognizes that these entities will need time to build their infrastructure, including the use of electronic health records, to be able to serve eligible enrollees as envisioned under each care coordination model. Care coordination fees are paid based on the individual plans' care coordination model and each plan has a goal to be cost neutral over three (3) years through reduced use of emergency rooms, reduced hospital admissions and readmissions, follow-up care and other strategies. HFS collects detailed data from each model and the data will be used to measure and assess the performance of the various models of care coordination into reporting years 2015 and 2016.

IX. MENTAL HEALTH SERVICES

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 2014, the SASS program served in excess of 24,000 unique children and youth while the three Departments expended approximately $40 million in SASS funding for services and administrative costs.

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/

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 (June 2015).

X. MEDICAID PROVIDER ASSESSMENT PROGRAM

	Provider assessments			
Fiscal year	Total	Hospitals	Nursing facilities	ICFs/MR
Total	$ 12,497.80	$ 10,204.00	$ 1,850.80	$443.00
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
2014	1,389.0	1,180.8	189.1	19.1
Source:	Bureau of Hospital and Provider Services			

The Provider Assessment Program was implemented in July 1991. It was the result of a joint effort by the General Assembly, the affected health care industries, and the Department to secure funding necessary for the Medical Assistance Program.

The program makes use of a provision in federal law that allows States to claim federal financial participation (FFP) on payments for services that are funded from the receipts of eligible health care provider taxes. The availability of funds generated by the Provider Assessment Program has helped the Department provide critical institutional services to some of the neediest and most frail Illinois residents.

Since inception, these programs have generated over $25 billion in additional funding for the Medical Assistance Program ($12.5 billion in provider assessments and $12.5 billion in FFP).

During fiscal year 2014, hospitals, nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) continued to be assessed.

Last fiscal year a new hospital outpatient assessment was enacted which generated $306.0 million in assessments in Fiscal Year 2014.

XI. PROVIDER REIMBURSEMENT

To receive payment for medical care, services or supplies a provider must enroll and be approved for participation by the Department. Enrollment information can be found on the Department's Provider Enrollment web page.

At the end of fiscal year 2014, a total of 84,199 providers were enrolled with the Department, representing an increase of 7,654 providers over fiscal year 2013. 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 provider fee schedules can be found on the Department's Medicaid Reimbursement web page.

Following are descriptions of some of the Department's reimbursements to providers.

Affordable Care Act - Increased Payment for Primary Care Services

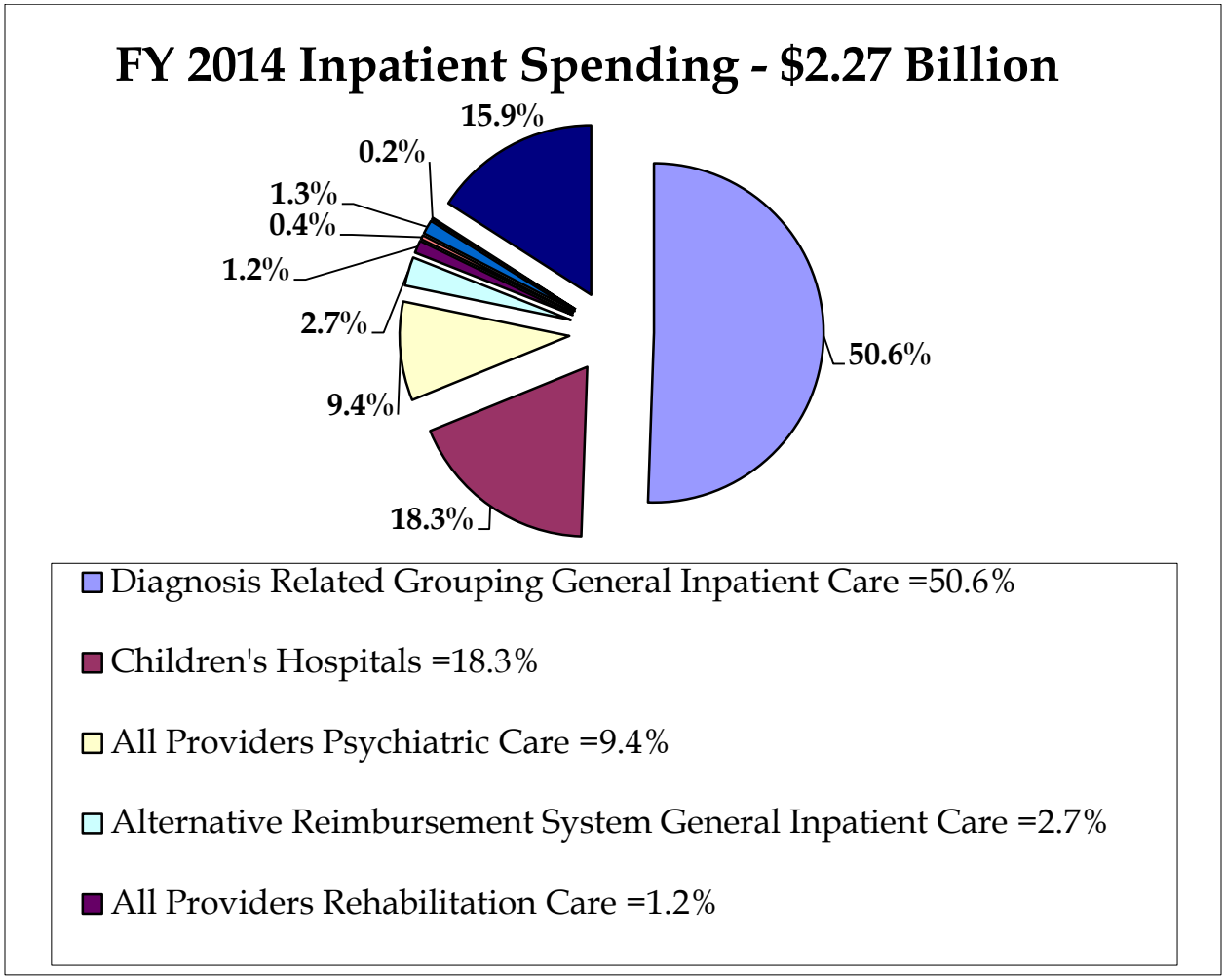
In January 2013, the Department implemented section 1202 of the Health Care and Education Reconciliation Act of 2010, which provides increased payments at the Medicare rate for certain Medicaid primary care services provided by certain qualified primary care providers. The increased rate applies to services 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.

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 2014 decreased one percent to $1.92 billion from the 2013 amount of $2.0 billion and utilization decreased by six percent. The decrease in utilization in fiscal year 2013 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 one percent and there was a 2.1 percent decrease in static payments. Consequently, the overall decrease in reimbursement for hospitals was 1.2 percent, down to $2.2 billion from $2.3 billion in fiscal year 2014.



Outpatient Hospital Services – GRF

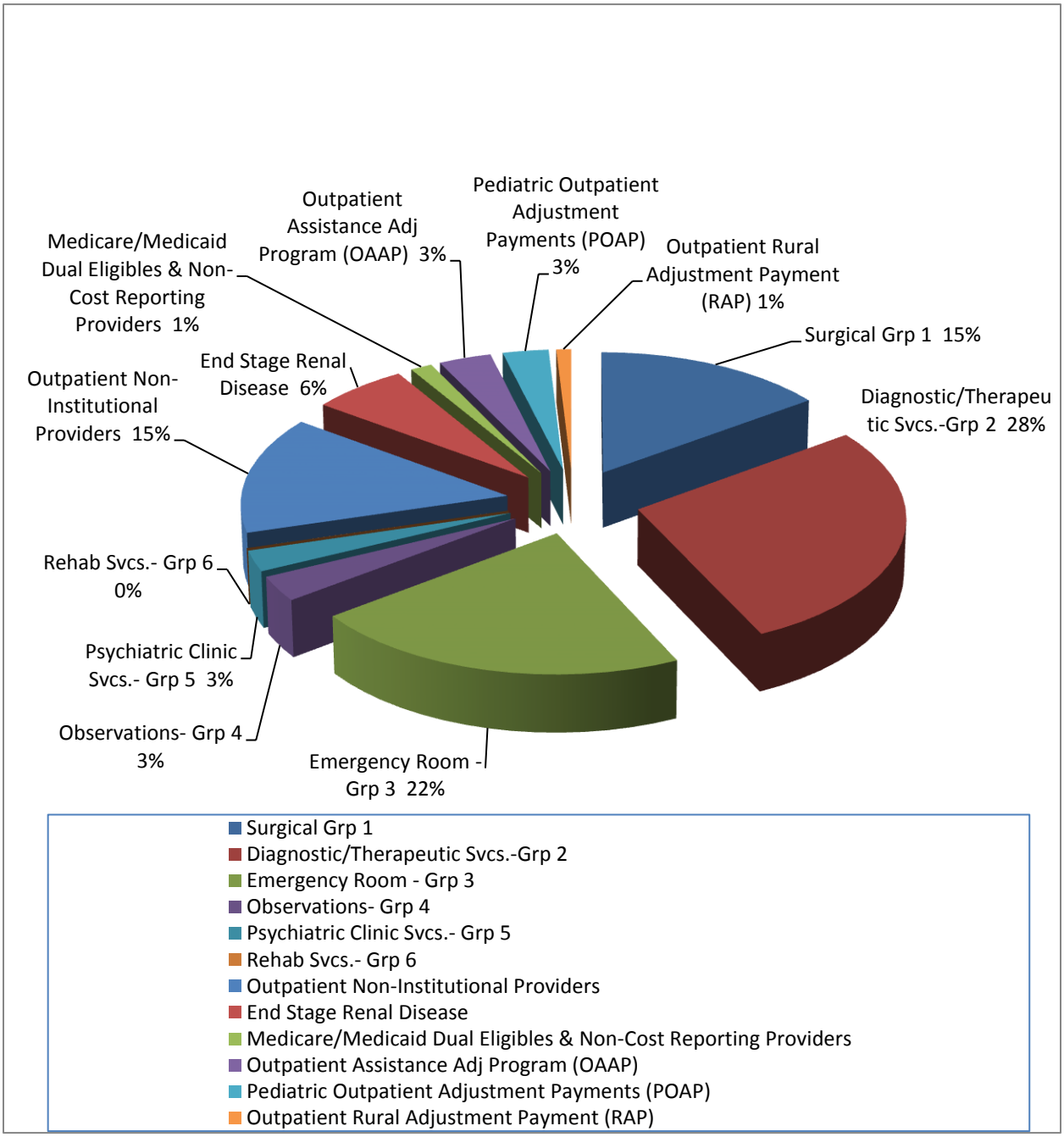
Ambulatory Care Services

Outpatient spending for fiscal year 2014 decreased approximately 3.5 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 2014 was $689 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 2014, including the Ambulatory Procedure Listing Payments, Outpatient Static Payments, Renal, and Non-institutional Providers. These payments are shown as a percentage of the total.

FY14 OUTPATIENT HOSPITAL SPENDING BY REIMBURSEMENT GROUP- $689 Million



FY 2014 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 2014, approximately $224 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 2014, this program distributed approximately $40.7 million to 39 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 2014, four qualifying rehabilitation hospitals received a little over $10.8 million in funding.
- Direct Hospital Adjustment: The Direct Hospital Adjustment is the largest component of the CHAP program. The Direct Hospital Adjustment provides additional funding to hospitals serving a high volume of Medicaid patients. Payment rates are based on a sliding scale that increases with the hospital's Medicaid and obstetrical care utilization. In fiscal year 2014, 30 qualifying hospitals received approximately $158.2 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 2014, 88 qualifying hospitals received approximately $14.1 million in payments through this program.

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 2014, the program paid approximately $4.2 million to six acute care facilities with specialized psychiatric care units.

Rural Adjustment Program

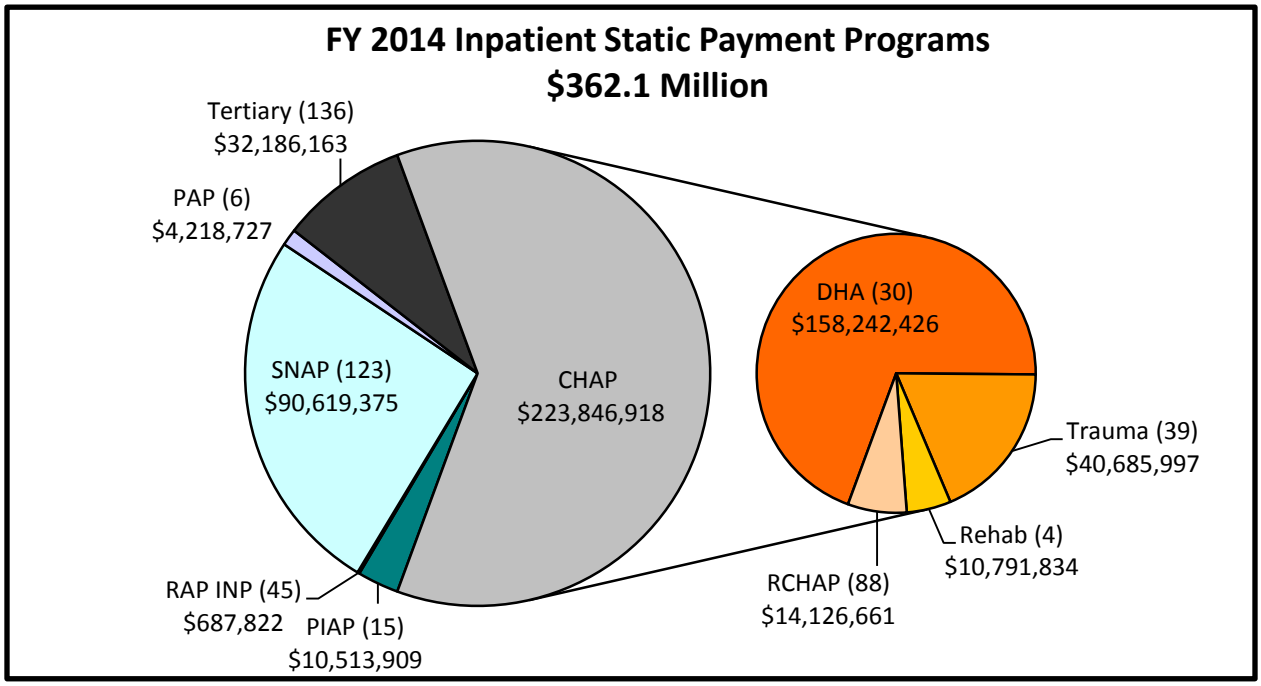
The Rural Adjustment Program provides additional funds to help close the cost coverage gap for hospital providers in rural areas, who have been deemed by the Department of Public Health, as critical to the provision of healthcare in Illinois. The program is divided into two distinct components to recognize 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 2014, a total of 45 providers qualified for the inpatient portion of the program with payments totaling approximately $688,000.

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 2014, a total of 122 providers qualified for the program with payments totaling $90.6 million.

Tertiary Care Adjustment Payments

The Tertiary Care Adjustment payments were designed to assist hospital providers in the delivery of greater access to essential, higher level complex healthcare services. A total of 136 providers qualified for Tertiary Care Adjustment payments during fiscal year 2014, 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 2014, 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 2014, program payment remained at $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 2014, 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 2014, 77 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 $75.6 million in federal fiscal year 2014 and the University of Illinois was paid $28.8 million. The average DSH payment for hospitals other than state operated psychiatric facilities and the University of Illinois was $6.39 per DSH day in fiscal year 2014, an increase from the $5.83 per DSH day paid in fiscal year 2013.

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 2014, 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 $49.11 to $325.07. Twenty-three children's hospitals received MHVA payments of $235.72 per day, and 68 other hospitals received MHVA payments of $117.86 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 2014, almost $10.1 million was paid out to Illinois' 64 qualifying Level I and Level II trauma centers.

XII. 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 submit 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 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 $138.21 on June 30, 2014

P.A. 098-0104 directed the Department to redesign its nursing rate methodology by January 1, 2014 based on the Federal RUG-IV 48 grouper methodology. The new nursing rate methodology is 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, provided 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 2014, 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. Two newly certified facilities received initial rates in FY14.
- *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 102 facilities in fiscal year 2014.
- *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 resulted in rate revisions for three 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 2014, 9,920 unduplicated Medicaid eligible residents participated in the program. At the end of fiscal year 2014, there were 142 SLFs, with a total of 11,427 apartments, in operation. This was a one percent increase in the number of SLFs and a two percent increase in the number of apartments available from the previous year. There were 21 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.

XIII. REIMBURSING CARE COORDINATION PLANS

Managed Care Organizations

Managed Care Organizations (MCOs) participating in the Department's Integrated Care Program (ICP), Voluntary Managed Care Program and Medicare-Medicaid Alignment Initiative (MMAI) demonstration 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.

Integrated Care Program

Under ICP, 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 six (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, ICP plans can earn incentive pool payments based on their performance of eleven (11) quality metrics for HEDIS 2014, calendar year 2013 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 incentive pool consists only of amounts withheld from capitation payments during the measurement year. Each plan's previous year's performance will be the baseline for that measurement year unless the previous year's performance was below the initial baseline, in which case the initial baseline remains the baseline.

The ICP Pay for Performance (P4P) measures address behavioral health, 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 Emergency Department visits, and Emergency Department utilization. For HEDIS 2014, Aetna Better Health met the Department's performance goal in five (5) measures and improved in seventeen (17) of the twenty (20) components of the P4P measures. IlliniCare met the Department's performance goal in two (2) measures and improved in eighteen (18) of the twenty (20) components of the P4P measures.

Voluntary Managed Care Program

In the Voluntary Managed Care Program, the capitation was 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 were payments for hospital deliveries. The Department reimbursed voluntary MCOs separately for each hospital delivery paid by the MCO. The payments for deliveries were generated by the Department based on the MCO's hospital encounter data that groups into specific diagnostic related groupings (DRGs). The Voluntary Managed Care program contracts ended June 30, 2014 and the participants were covered under the mandatory Family Health Plan (FHP)/Affordable Care Act (ACA) program effective July 1, 2014. As described in the ICP section above, similar MLR and P4P measures apply to this program as well.

Medicare-Medicaid Alignment Initiative

MMAI demonstration contracts are three (3)-party agreements between federal Centers for Medicare and Medicaid Services (CMS), the Department and each MCO, so both CMS and the Department contribute to the global capitation payment. CMS and the Department each make monthly payments to the MCOs for their

components of the capitated rate. MCOs receive three (3) monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services, one amount from CMS reflecting coverage of Medicare Part D services, and a third amount from the Department reflecting coverage of Medicaid services.

Primary Care Case Management – Illinois Health Connect

Primary Care Physicians (PCPs) participating in the Illinois Health Connect (IHC) Program 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 Combos
- 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 2013 Bonus Program, the Department issued over $4.5 million in bonus payments to qualifying PCPs.

Care Coordination Entities and Accountable Care Entities

Care Coordination Entities (CCEs), serving Seniors and Persons with Disabilities or Children with Special Needs, and Accountable Care Entities (ACEs) receive a monthly care management fee for care coordination services. Providers participating in a CCE or ACE network receive fee-for-service payments for medical services rendered in accordance with Department reimbursement policies. PCPs participating in a CCE's network must be enrolled as a PCP in IHC. These PCPs receive the monthly IHC care management fee for each participant they accept as a patient. The fee is paid directly to 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 CCE or ACE network also qualify for the IHC Bonus Program.

XIV. 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 2014, 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 2014, 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 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.

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 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 FY14, $36.9M in third party payment was reported on pharmacy claims. This is an increase from $33M reported on claims with dates of service during FY13. For dates of service during FY14, the calculated third party payment per prescription was $2.28. This is an increase from $1.73 the calculated third party payment per prescription during FY13.

Drug Prior Approval System

The Department implemented a web-based drug prior approval system in FY12. Expanded last fiscal year, the Department has continued 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 2014, the Department collected approximately $11 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 FY14. Since the initial filing, HFS staff has provided information and expertise through discovery, responses to interrogatories, depositions, and testimony. During FY14, three additional drug manufacturers settled with the state for a total of $137M. This brings the total settlement amount to approximately $301.4M at the end of FY14. The lawsuit is ongoing.

XV. 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 292,000 Illinois school children participating in the School-Based Health Services program received direct medical services during fiscal year 2014. Local Education Agencies received reimbursement of more than $90.8 million for their costs to provide these services and more than $52.6 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: <http://www.sbhsillinois.com/>

XVI. 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 2014, the RHC program had 240 sites 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 2014, medical encounter rates for RHCs ranged from $47.74 to $91.96 and behavioral health encounter rates ranged from $52.93 to $74.01.

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 2014, there were 386 FQHC 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 2014, medical encounter rates for FQHCs ranged from $90.86 to $136.86 and behavioral health encounter rates ranged from $37.88 to $57.64.

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 Authorization 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 service complies with federal requirements. The program ensures: 1) transport is to a covered medical service; 2) transport is via the most cost effective mode, meeting the medical needs of the participant, and; 3) the participant is being transported to the closest appropriate medical provider. The NETSPAP is currently administered by First Transit, Inc. The NETSPAP vendor is responsible for the screening and prior authorization adjudication process for all non-emergency medical transportation. During the fiscal year 2014, the program processed 516,542 non-emergency transportation transactions. The reduction in NETSPAP transactions processed between 2013 and 2014 is due to the transition of Medicaid participants to care coordination entities. The NETSPAP contract award notice was published July 17, 2014 with contract effective date August 30, 2014.

As a result of *Public At 097-0698*, 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 with dates of service on and after 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. Within that certification, the provider is attesting that a lower level of transportation service (service car/Medicar/wheelchair van/taxi/private automobile) is contraindicated.

XVII. QUALITY ASSURANCE, UTILIZATION AND CONTROL

CHIPRA Quality Demonstration Grant - Improving the Quality of Children's Health Care

The CHIPRA Quality Demonstration Grant was awarded for a five-year period beginning in February 2010 and continuing to February 2015. In late 2014, CMS offered the opportunity for CHIPRA grantee states to request no-cost extensions for up to one additional year. A one-year no-cost extension was approved by CMS which will allow the CHIPRA grant to continue through February 2016. During the extension period, HFS will work on improving and sustaining many CHIPRA accomplishments.

1. *Child Health Quality Measures*

HFS has integrated reporting of the Child Core Set measures into its ongoing operations and will continue to report annually on the measures as referenced in Section VI, Maternal and Child Health Promotion. In addition, HFS will work to develop an infrastructure to move from measurement/reporting to quality improvement.

2. *Health Information Exchange (HIE) and Health Information Technology (HIT)*

The CHIPRA grant developed a Prenatal Minimum Electronic Data Set (PMEDS), a tool to utilize HIT to improve the timely and appropriate use of perinatal care services and improve birth outcomes. An expert workgroup developed and finalized a set of data elements related to prenatal care that will be available to prenatal and hospital providers, assuring all providers have access to key data regarding a pregnancy regardless of where the patient receives care. This tool will be pilot tested in 2015.

3. *Enhancing the Delivery System - Patient-Centered Medical Homes (PCMH)*

The CHIPRA PCMH/Asthma Learning Collaborative kicked off in May 2014 and and concluded in February 2015. Fifteen practices participated (4 downstate and 11 in the Chicago area). Monthly review of data shows significant improvement in asthma care and adoption of PCMH principles in these practices. A final report will be released in 2015. Two practices are involved in a facilitation project and both expect to submit applications for PCMH recognition in 2015. A workgroup met throughout 2013 to develop recommendations for HFS support of PCMH transformation with the recommendations/report issued in 2014, resulting in PCMH requirements included in managed care contracts. PCMH work will continue during 2015 with the facilitation project and sustainability efforts.

4. *Improving Birth Outcomes*

The CHIPRA Quality Demonstration Grant includes a focus on improving birth outcomes. A number of resources and tools have been developed, including a prenatal minimum electronic data set, a prenatal care quality tool, best practices for perinatal care transition, and a toolkit focused on educating women about preconception, prenatal, postpartum and interconception care. A postpartum care study is underway with the University of Illinois at Chicago and CHIPRA supported the creation of the Illinois Perinatal Quality Collaborative (ILPQC), a voluntary hospital-focused quality improvement collaborative that uses best practices and quality improvement science to improve the quality of perinatal care and birth outcomes for women and infants with focus on both obstetrical and neonatal care. Projects implemented in 2014 include reduction of early elective delivery and a Neonatal Intensive Care Unit (NICU) infant nutrition and feeding initiative. During the no-cost extension period, testing of the referenced tools will be completed, the UIC postpartum study will be completed, and the ILPQC will implement three new quality improvement initiatives focused on maternal hypertension, the Golden Hour, and improving accuracy of birth certificate data.

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 Department executed an EQRO contract with Health Services Advisory Group (HSAG) for a three (3) year term beginning January 1, 2013 and ending December 31, 2015, with three (3) one-year options to renew thereafter. HSAG provides federally-required External Quality Review activities including readiness reviews for new plans prior to implementation, as well as technical assistance, to Managed Care Entities (MCEs) which include all care coordination programs

developed by HFS, including Voluntary Managed Care Organizations [transitioned to Family Health Program (FHP)/Affordable Care Act (ACA) health plans in the summer of 2014], the Integrated Care Program (ICP), the Medicare-Medicaid Alignment Initiative (MMAI), Care Coordination Entities (CCEs), Accountable Care Entities (ACEs), and other programs developed under the Department's Innovations Program. In addition, HSAG performs an annual separate Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for both the Medicaid Program and the Children's Health Insurance Program (CHIP) (Titles XIX and XXI), which includes the Children with Chronic Conditions questions, provides quality oversight and monitoring of waiver providers through record review audits of enrollee care plans for ICP, MMAI, and any other MCE, and monitors the quality of services and supports provided to Home and Community Based Services (HCBS) program enrollees.

HFS has nine (9) contracted MCOs in the FHP/ACA program and ten (10) MCOs in ICP. On March 1, 2014, HFS began enrollment of dual-eligible (Medicare and Medicaid) clients into MMAI, which includes eight (8) MCOs.

During the reporting period for State Fiscal Year 2014 (July 1, 2013 – June 30, 2014), HFS entered into contracts with five (5) CCEs under the Department's Innovations Program, further expanding its care coordination programs. These contracts were effective and received enrollment during the identified reporting period. As the State continued the expansion of its care coordination programs, as mandated by Illinois Public Act 96-1501, an additional three (3) CCEs were implemented. Two (2) Children with Special Needs (CSN) CCEs and one (1) Seniors and Persons with Disabilities (SPD) CCE were added, making a total of eight (8) CCEs. The CSN CCEs and the SPD CCE became effective and received enrollment after the reporting period, commencing in July 2014.

The contracts with all nine (9) ACEs were executed in July and August 2014, after the reporting period. Enrollment into ACEs did not begin until late July 2014 in the Central Illinois region and August 2014 in the Quad Cities and Rockford regions.

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. HFS is currently updating the Quality Strategy for 2014-2015.

HFS has identified the following five (5) 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 (3) federally-mandated External Quality Review activities: compliance monitoring evaluation, validation of performance measures, and validation of performance improvement projects.

The EQR Technical Report focuses on an analysis of each MCO's performance in the area of quality assurance and quality monitoring and identifies recommendations for improvement. The reports are available on the Department's website at:

http://www2.illinois.gov/hfs/SiteCollectionDocuments/2010-2011ExternalQualityReviewAnnualReport.pdf
http://www2.illinois.gov/hfs/SiteCollectionDocuments/IL201112EQRTRF1.pdf

State Medicaid agencies are required to provide utilization review and quality assurance in the inpatient hospital setting for services provided to fee-for-service participants in the Medical Assistance program. The Department contracts with eQHealth Solutions, a federally designated QIO-like entity, to provide these services. eQHealth Solutions performs quality studies and other initiatives designed to identify issues of concern and improve the quality of care and recommends 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.

In FY14, non-certification of medically unnecessary services resulted in direct cost savings of $20.6 million for a cumulative savings exceeding $281 million since 2002. The FY14 return on investment is $4.43 saved for every dollar invested in eQHealth Solutions. The following types of reviews are performed:

- Utilization Review

Utilization review is the process of determining the medical necessity and appropriateness of an acute care hospitalization. eQHealth Solutions' nurse reviewer or utilization review coordinator (URC) applies current InterQual® criteria specific to the patient's condition. If criteria are satisfied, Truven Analytics' Length of Stay Norms is referenced to determine the number of certifiable days. There are four types of reviews:

  - Pre-certification (or prior authorization) – conducted on selected procedures before a participant is hospitalized;
  - Concurrent review – conducted via a secured web portal or by telephone while the patient is hospitalized;
    - Admission review – the first review conducted after the inpatient hospitalization.
    - Concurrent/Continued Stay review – when the provider anticipates additional days of care beyond the last date certified, a continued stay review is performed.
  - Retrospective review – performed at one of two points following discharge:
    - Prepayment – a medical record review conducted after discharge and prior to payment to the hospital.
    - Post-payment review – a medical record review for a sample of defined categories of hospitalizations conducted after discharge and after the hospital has been paid.

- Quality Review

In addition to evaluating the medical necessity and appropriateness 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.

Review Activity/Volume

- Concurrent and pre-payment reviews

In fiscal year 2014, eQHealth conducted 177,137 concurrent and prepayment reviews associated with 103,067 hospitalizations. Compared to FY13, the volume of hospitalizations increased by 0.7%, whereas the total review volume decreased by 4.2%. A total of 83,467 child and adolescent psychiatric hospitalization reviews were performed which represents 47.2% of the total volume of all hospitalizations concurrently reviewed.

- Post-Payment reviews

During this reporting period 6,308 post-payment reviews were conducted which is up from 3,984 post pay reviews conducted last fiscal year.

Review Outcomes

- Concurrent and pre-payment

During fiscal year 2014, a total of 21,742 reviews were referred to physician reviewers for additional evaluation representing 12.3% of reviews conducted. For this reporting period, the denial rate was 18.5% which is up from 12.9% in FY13. A denial is defined as a review referred for medical necessity that has one or more days non-certified. Of notable interest, 8% involved admission denials and 10.5% were length of stay denials.

- Post-Payment

During fiscal year 2014, 383 reviews were referred due to a failed quality screen. It should be noted that one referral can include multiple failed quality screens. The physician reviewer addresses each failed quality screen individually. First level physician review determined 311 failed screens had at least one quality concern of a minimal, moderate, or serious risk. Moderate and serious quality concerns represented 59.2% of the quality issues identified in post-pay review.

SMART Act and Other Review Initiatives

- 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 important to note that this category of clinical service serves the fewest number of participants but is associated with the highest rate of admissions. This year 9,725 detox reviews were conducted, 630 (6.5%) reviews were referred for physician review, with a denial rate of 12.9%.

- Medically unnecessary cesarean sections – eQHealth evaluates the medical necessity of cesarean deliveries. Payments for cases determined to be medically unnecessary are reduced to the lower vaginal delivery rate. If the medical record is not received, the review is canceled and no payment is made. During FY14, 1,243 cesarean deliveries were reviewed, 220 records were referred for physician review, and 53 cases were determined to be medically unnecessary.

At the outset, eQHealth requested a statistical sample of maternity health records to review. However, during the first year of review, the non-response rate averaged 8.1% of the sampled population. Many of the non-responders were subsequently reimbursed at the Cesarean delivery rate. To determine the financial impact to non-responding providers, eQHealth tracked all the non-responsive records within the inpatient claims data. eQHealth identified 51 non-responsive c-section claims. Of the 51 claims, 46 hospitalizations (90.2%) were paid with amounts ranging from $2,300 to 4,270. As a result and to ensure program adherence, HFS implemented a program modification to review ALL cesarean deliveries effective September 12, 2014.

- Prior Authorization of Coronary Artery Bypass Graft (CABG) and Back Surgery –The SMART Act identified these two clinical procedures as areas of potential cost savings. We implemented prior authorization of elective CABG and back surgeries effective for admissions on or after April 1, 2014. A total of 602 reviews were completed (40 CABG, 562 Back Surgery), 150 reviews were referred for physician review. Only 1 review was denied due to the fact that the requesting facility failed to notify eQHealth of the treating physician's change in proposed procedure. To date, prior authorization for these two services has failed to yield the expected cost savings.

- One Day Stays Pre-payment Review – one day hospitalizations often represent an area of over-utilization where an observational setting may have been clinically appropriate. Effective with admissions on or after 10/1/2013, HFS implemented pre-payment review of seven high liability, high volume admitting diagnoses. During this reporting period, 1,149 medical reviews were completed of which 253 were referred for physician review. Of the 253 physician reviews, 59 hospitalizations (23%) were denied which represents 5.1% of the total hospitalizations for this population.

Special Projects, Collaboration, and Report Activity

eQHealth continues to support HFS by performing special projects and ad hoc data analyses which assists 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 as well as their insight into provider challenges. eQHealth's Provider outreach program is a combination of:

- Provider communications – ensures providers are consistently updated on Medicaid policies and review procedures as well as develops and distributes 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 – evaluates providers' care delivery to safeguard patient safety

Long Term Acute Care (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 an LTAC facility. LTAC facilities are paid a supplemental per diem rate for patients who meet the requirements of the Act. eQHealth successfully implemented the LTAC 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 a qualified LTAC hospital 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 2014, a total of 7,943 LTAC reviews were conducted for 2,016 LTAC hospitalizations. Medical/Surgical reviews comprised 88.7 percent of the review volume while 11.3 percent of the review volume was attributed to psych admissions. LTAC hospitals' certified days totaled 57,795 with 570 days denied. The Average Length of Stay (ALOS) among all LTAC providers was 29 days.

The Act also requires specific quality measures to be monitored and reported. The following seven quality indicators impact the rate adjustment:

- Ventilator weaning rates
- Central line blood infections
- Acquired stage 3 or 4 pressure ulcers
- Patient falls with moderate or greater injuries
- Patient falls without injury
- Catheter associated urinary tract infections
- Ventilator associated pneumonia

The following additional data items are collected but do not impact the rate adjustment:

- Average length of stay
- Mortality rate
- Patients requiring wound care

As required by the LTAC Act, a Continuity and Record Evaluation (CARE) tool must be submitted after the patient is discharged. The CARE tool is a comprehensive assessment designed to provide an overview of a patient's demographic, clinical, functional and cognitive status at the time of admission and discharge. LTAC hospitals are also required to submit a federal version of the CARE tool to Centers for Medicare and Medicaid (CMS). During 2014 in an effort to streamline LTAC hospitals' reporting requirements, HFS and eQHealth together with LTAC representatives worked collaboratively to draft legislation which amended the Act to comply with CMS CARE tool data collection and electronic transmission reporting requirements. HFS continues to collect important supplemental quality indicator data outside of the federal CARE tool.

Home and Community Based (HCBS) Waiver Program Oversight, Monitoring, and Administrative Coordination

HFS, as the 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 several 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 department's federally funded Quality Improvement Organization.

Keystone Peer Review Organization (KEPRO) conducts quality reviews for the HCBS waivers to assure that contract expectations for quality oversight are met. It performs comprehensive provider reviews for five waivers and individual record reviews (based on representative samples, as required by federal CMS) for four waivers. KEPRO does not conduct reviews for 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 2014 Activity

During Fiscal Year 2014, the OIG successfully implemented legislative and enforcement initiatives that resulted in $94.4 million dollars in cost savings, avoidance, and recoupment for the taxpayers of Illinois. See our annual reports at http://www.state.il.us/agency/oig/default.asp

XVIII. 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 133 percent of the federal poverty level (monthly income of $1,342/individual, $1,809/couple) qualified for Medicaid January 2014 was the first possible month of coverage for these individuals.

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 2014, about 2.5 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 18 years of age living in their home. Adults must live in Illinois and be U.S. citizens or legal permanent residents in the country for a minimum of five years or have another federally Medicaid qualifying immigration status. 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.familycareillinois.com.

The All Kids Web site is maintained to provide easily accessible and current information about the program. Families may apply online through both an English and Spanish Web-based application. Both English and Spanish applications are also available for download by persons who want to apply for All Kids by mail. Those using the Web site may also ask questions about the program. Information is provided about income guidelines, cost sharing, and All Kids Application Agents (AKAAs). AKAAs continue to be a successful component of the overall outreach program. Currently there were 473 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 2013, 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, adults must have countable family income within 133* percent of the FPL ($2,743 per month for a family of four) for adults and up to 142%* for the children to be eligible. ($2.922 per month for a family of four). Children covered under All Kids Assist have no copayments or premiums. FamilyCare Assist parents have copayments of $3.90 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 142* percent and at or below 157 percent of the FPL (between $2,923 and $3,120 a month for a family of four).

Children in All Kids Share have a $2.00 or $3.90 copayment or less 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 157 percent and at or below 209 percent of the FPL (between $3,121 and $4,154 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 209 percent and at or below 313* percent of the FPL (between $4,155 and $6,320). 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 ended as of December 31, 2013. It provided 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. Due to the federal subsidies under the ACA, the rebate program was no longer necessary.

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 208***** percent of the FPL (at or below $4,233 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.

*****As required under the Affordable Care Act, a five percent income disregard is allowed for these programs.

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 2014, 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 250 percent of the FPL. Under the program, the Department of Public Health provides screenings for breast and cervical cancer. The Department administers the treatment portion of the program. Individuals who are not enrolled in BCC should call the DPH Women's Health Line 1-888-522-1282 (1-800-547-0466 TTY).The Women's Health Line will be able to walk women through the eligibility requirements and the screening process. Those who are already receiving coverage under the treatment portion of the program may call the Department's BCC Unit at 1-866-460-0913 (1-877-204-1012 TTY).

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

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

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. IHW was phased out in 2014 with all IHW coverage ending effective December 31, 2104. New applications were no longer accepted after September 30, 2014. All women in the program and those who applied were encouraged to apply for more comprehensive coverage through the ACA.

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

During fiscal year 2014, HBWD provided health coverage to a monthly average of 725 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 $7,160 for a single person and $10,750 for a couple. The federal government shares in the cost of this coverage.

Pay-In Spenddown provides AABD individuals whose income and/or assets are too high for regular Medicaid to enroll and pay their spenddown amount to the Department, rather than having to accumulate bills and receipts of medical expenses on a monthly basis and provide them to the DHS caseworker. During fiscal year 2014, the Pay-In spend down program enrolled an additional 13,000 individuals for total enrollment of over 34,000. The unit also processed over 13,000 payments.

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. Patients who are Illinois residents, and meet requirements of U.S. Citizenship and whose kidneys are non-functioning or absent and require dialysis treatment to maintain life are eligible. The Program is supplementary to all other resources, including Medicare, Medicaid, private insurance and private income. The Department of Healthcare and Family Services is the payer of last resort after private insurance and Medicare. In accordance with **Public Act 98-0104**, patients must meet their obligations under ACA and may be required to obtain and provide proof of health coverage to the Department before they become

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

enrolled in this program. The program covers treatment in a dialysis facility, treatment in an outpatient hospital setting and home dialysis, including patients residing in a long-term 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. Eligibility for the program is reviewed and determined on an annual basis. These benefits are financed entirely with state funds. Individuals may learn more or download an application at http://illinois.gov/hfs/MedicalCustomers/renal

State Sexual Assault Survivors Emergency Treatment Program[1] pays emergency outpatient medical expenses and 90 days of related follow-up medical care for survivors of sexual assault. The program will reimburse an Illinois hospital for a patient's initial emergency room (ER) visit and for related follow-up care for 90 days following the initial ER visit. If the patient receives a voucher at the hospital for the program's follow-up program, then the patient can seek their 90 days of follow-up care from the community providers of their choosing. The Department maintains an on-line registry for hospitals to register the sexual assault survivor in order to produce a voucher that allows the survivor to obtain needed follow-up care outside of an Illinois hospital. The program is always the payer of last resort, meaning that it only pays after other third party payers, such as private insurance or Medicare, have made a benefit determination. Participants currently eligible for Medicaid are not eligible to receive benefits under this program. Additional information about this program can be found in the Chapter 100 Handbook on the Department's Web site.

Veterans Care provides comprehensive healthcare to uninsured veterans under age 65 who were honorably discharged from the military, are income eligible, and are not eligible for federal healthcare through the U.S Veterans Administration. Eligible individuals pay a monthly premium of either $40 or $70 depending on their income. By the end of fiscal year 2014, 1,100 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 covered 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. Persons who qualify for Medicaid under the Family Health Plans, AABD or ACA Adult programs are ineligible for the Refugee Program. Effective January 2014, adults who would have previously been enrolled in this program became eligible for the ACA Adult program. As a result the Refuge Program ended in 2014.

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.

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

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 was approved through 2019.

During federal fiscal year 2014, it is estimated that close to the 700 projected unduplicated children will have been 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.

On July 9, 2013, Federal Court granted preliminary approval to a Class Action Settlement - Hampe Consent Decree. The settlement was reached to resolve the case and to continue to provide medically necessary benefits to Class Members after they turn 21 years old. On October 3, 2013, the Court conducted a fairness hearing and determined the terms of the Consent Decree to be fair, reasonable, and adequate. The Hampe Consent Decree allows the benefits of the MFTD waiver to be extended to the Class and is to be in effect for three years from date of entry. Per the terms of the Consent Decree, care coordination to Hampe Class Members is being provided by DSCC.

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, a revised participant level 18,537 individuals were served. In federal fiscal year 2014, the state estimates that around 20,000+ individuals will have received services under the waiver. This growth in capacity reflects previous year's increase due to the Ligas Consent Decree.

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. An amendment was submitted in federal fiscal year 2014 to add ACA adults age 19-64 and Former Foster Care group to this waiver, and additional services supporting behavioral health. This amendment remains pending as discussions with federal CMS continue regarding the additional service(s).

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 2014, an amendment was submitted and approved to increase the waiver capacity in waiver years four and five to 1440; add ACA adults age 19-64 without dependent children and with income at or below 138% of the Federal Poverty Level in order to provide services of relevance to this population; and Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets. Eligibility for this group continues until the 26th birthday.

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. CMS approved the waiver renewal, effective July 1, 2010 to June 30, 2015.

During federal fiscal year 2013, an amendment was granted to increase waiver capacity from 280 to 295 in order to serve more persons. A further amendment was submitted and approved in federal fiscal year 2014 to include: ACA adults age 19-64 without dependent children and with income at or below 138% of the Federal Poverty Level in order to provide services of relevance to this population; and Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets. Eligibility for this group continues until the 26th birthday.

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, the final numbers reflect that4,361 persons were served.

In federal fiscal year 2013, the renewal for this waiver was approved, with an effective date of July 1, 2012. In addition, a February 1, 2013 amendment was submitted and approved to allow the state to deliver care coordination and waiver services through a mandatory managed care delivery system for participants enrolled in the State's Integrated Care Program (ICP). In addition, in February 2014, approval was received of an amendment to include those participants whose waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) and under the Managed Long-term Supports and Services (MLTSS) 1915(b) waiver the greater Chicago and Central Illinois regions. Beginning on March 1, 2014, participants were voluntarily enrolled in MMAI. Passive enrollment began June 1, 2014.

Additional amendments in federal fiscal year 2014 were submitted and approved to include: ACA adults age 19-64 without dependent children and with income at or below 138% of the Federal Poverty Level in order to provide services of relevance to this population; and Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets. Eligibility for this group continues until the 26th birthday.

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.

On February 1, 2013 an amendment was submitted and approved to allow the state to deliver care coordination and waiver services through a mandatory managed care delivery system for participants enrolled in the State's Integrated Care Program (ICP). In addition, in February 2014, approval was received of an amendment to include those participants whose waiver services will be administered under the Medicare

Medicaid Alignment Initiative (MMAI) and under the Managed Long-term Supports and Services (MLTSS) 1915(b) waiver the greater Chicago and Central Illinois regions. Beginning on March 1, 2014, participants were voluntarily enrolled in MMAI. Passive enrollment began June 1, 2014.

Additional amendments in federal fiscal year 2014 were submitted and approved to include: ACA adults age 19-64 without dependent children and with income at or below 138% of the Federal Poverty Level in order to provide services of relevance to this population; and Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets. Eligibility for this group continues until the 26th birthday.

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. In 2014, federal CMS approved an extension to this waiver through early 2015.

On February 1, 2013 an amendment was submitted and approved to allow the state to deliver care coordination and waiver services through a mandatory managed care delivery system for participants enrolled in the State's Integrated Care Program (ICP). In addition, in February 2014, approval was received of an amendment to include those participants whose waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) and under the Managed Long-term Supports and Services (MLTSS) 1915(b) waiver the greater Chicago and Central Illinois regions. Beginning on March 1, 2014, participants were voluntarily enrolled in MMAI. Passive enrollment began June 1, 2014.

Additional amendments in federal fiscal year 2014 were submitted and approved to include: ACA adults age 19-64 without dependent children and with income at or below 138% of the Federal Poverty Level in order to provide services of relevance to this population; and Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets. Eligibility for this group continues until the 26th birthday.

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 2014, the waiver was amended to increase capacity for waiver year 2014 up to 57,000 participants. In 2014, federal CMS approved an extension to this waiver through early 2015.

On February 1, 2013 an amendment was submitted and approved to allow the state to deliver care coordination and waiver services through a mandatory managed care delivery system for participants enrolled in the State's Integrated Care Program (ICP). In addition, in February 2014, approval was received of an amendment to include those participants whose waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) and under the Managed Long-term Supports and Services (MLTSS) 1915(b) waiver the greater Chicago and Central Illinois regions. Beginning on March 1, 2014, participants were voluntarily enrolled in MMAI. Passive enrollment began June 1, 2014.

Additional amendments in federal fiscal year 2014 were submitted and approved to include: ACA adults age 19-64 without dependent children and with income at or below 138% of the Federal Poverty Level in order to provide services of relevance to this population; and Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets. Eligibility for this group continues until the 26th birthday.

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 2014, 9,920 unduplicated Medicaid eligible residents participated in the program. At the end of fiscal year 2014, there were 142 SLFs, with a total of 11,427 apartments, in operation. This was a one percent increase in the number of SLFs and a two percent increase in the number of apartments available from the previous year. There were 21 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.

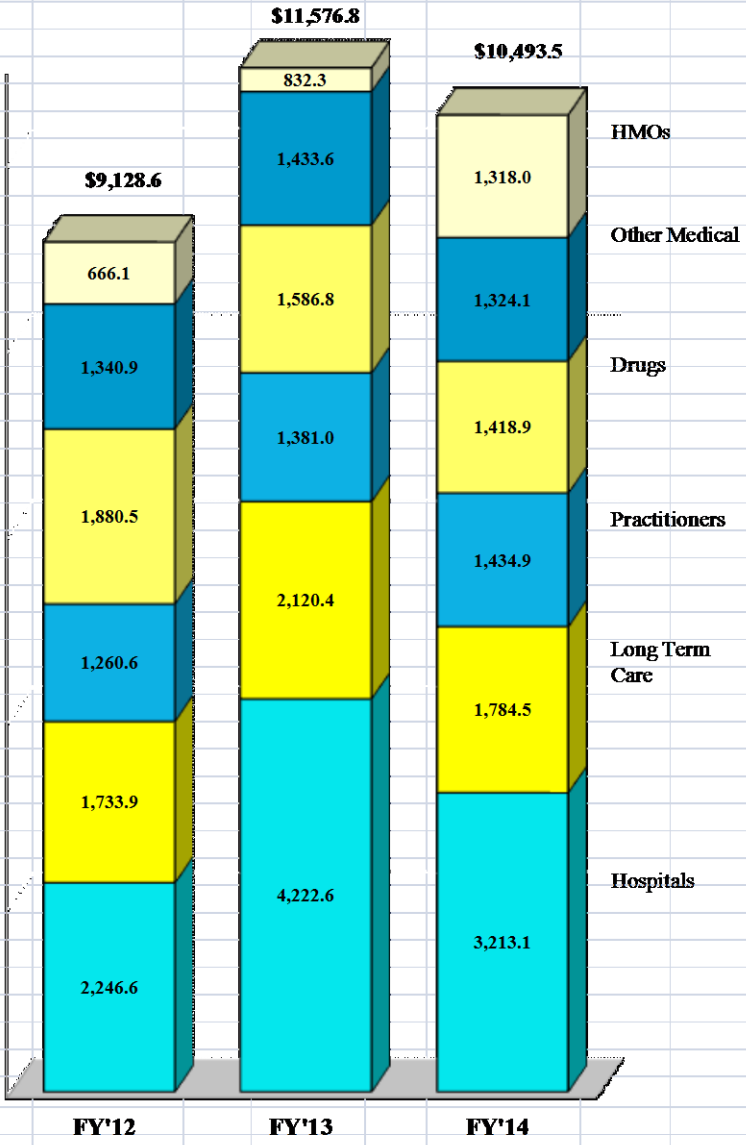
Supportive Living Facilities provide an assisted living-style setting that offers an individual who has been determined to be at risk of nursing facility admission an alternative to prevent or delay admission to the more restrictive and costly nursing facility setting.

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.

XIX. GRAPHS

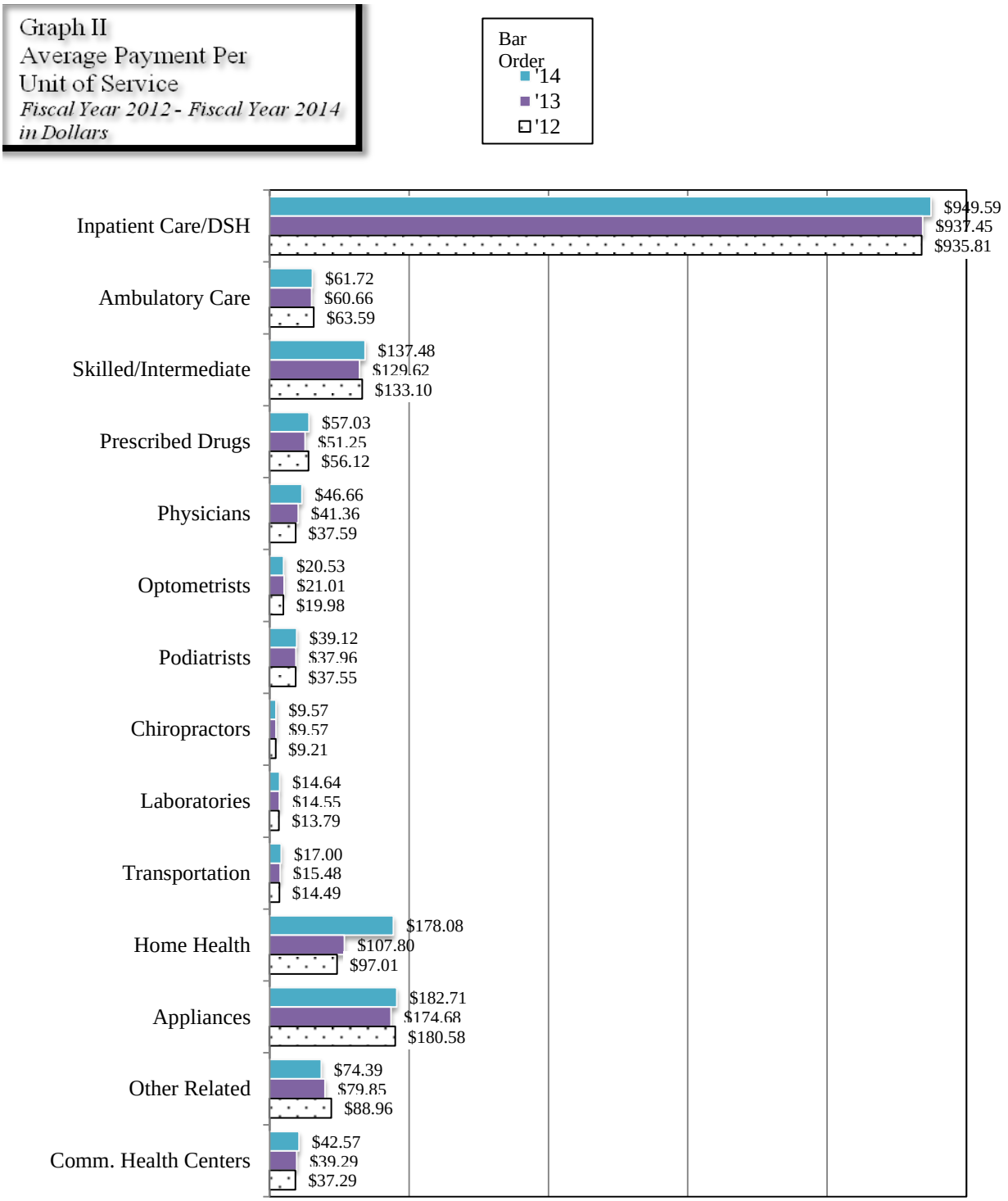
Graph I
Medical Programs Spending
Fiscal Year 2012-Fiscal Year 2014
Dollars in Millions

Fiscal Year	Events That Affected Spending
2012	Reflects 11 months of long term liability instead of 12 related to PA 96-1405. 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 resulted in approximately $2.5 billion in unpaid bills being pushed into FY13 creating longer payment cycles. Other Medical includes amounts paid via offsets to ffp draws.
2013	SMART Act reductions implemented per PA 097-689. FY13 lapse period spending extended through 12/31/13. Includes 748 Hospital Relief Fund $280 million re-appropriation. Other Medical includes amounts paid via offsets to ffp draws. Includes paydown of unpaid bills accumulated during FY'12.
2014	Integrated Care program expanded throughout other regions of that state in HMOs. Other Medical includes amounts paid via offsets to ffp draws.



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

Graph Prepared By: Division of Finance
Data Source: Division of Finance, Comptroller Spending Report FY'14.



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.

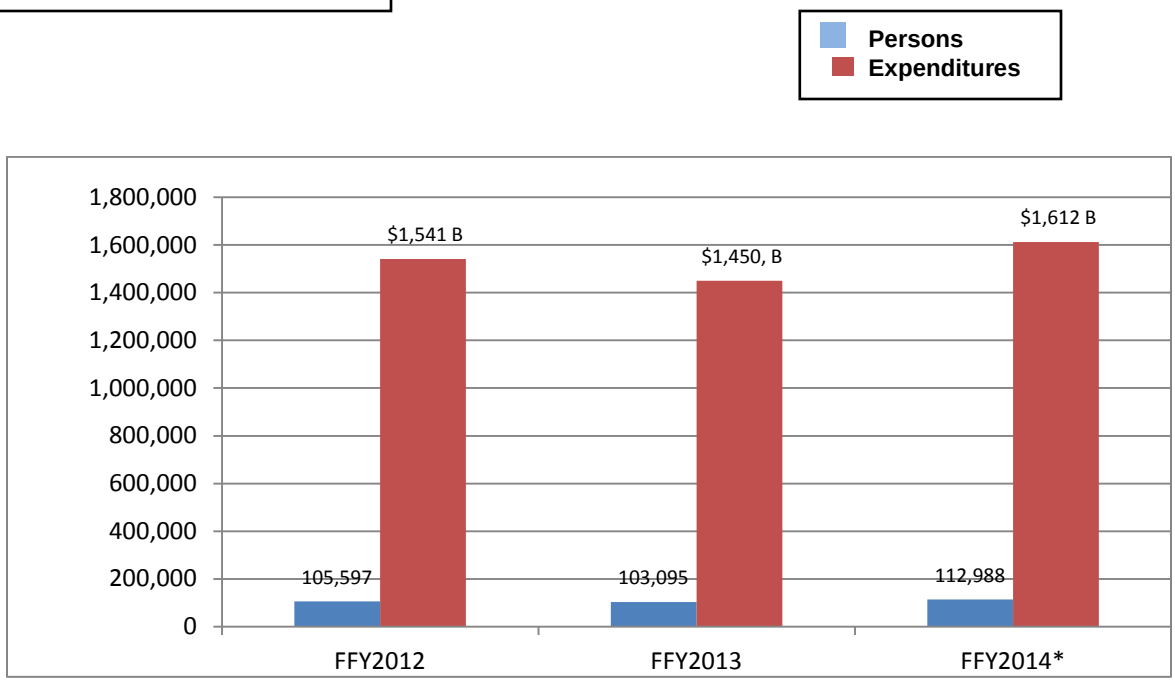
Average payment rate after adjustments for patient co-payments, third party liability, bed reserves, etc.

For LTC, a unit of service is a day, while in physicians, it is a single procedure code.

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

Graphs Prepared By: Division of Finance

Graph III
Medicaid Waiver Persons
and Expenditures
Waiver Years 2012 - 2014



Note: All data were compiled from federal 372 Report data, based on the waiver year periods applicable for the waivers. Client totals are based on combined annual totals of persons per 372 reports for HFS waivers managed by Departments on Aging, Human Services, Healthcare and Family Services and the Division of Specialized Care for Children. FFY 2014 numbers are based on data available as of March 20, 2015.

XX. TABLES

Table I
Licensed/Medicaid-Certified
Long Term Care Beds
Fiscal Year 2014 Actual

Level of Care	Medicaid Certified Beds [1]	Licensed Beds [2]
Skilled Care	68,343	78,010
Intermediate Care	14,548	16,302
Intermediate Care for the Mentally Retarded (ICF/MR)	5,377	5,377
Skilled Pediatric Care	932	932
Total	89,200	100,621

[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 and Department of Public Health

Table II
Long Term Care Total Charges and Liability on Claims Received
Fiscal Year 2012 - Fiscal Year 2014

	Long Term Care - Total			
	FY'12	FY'13	FY'14	Percent Change FY'12 to FY'14
Total Charges [1] ($ Millions)	$2,192.54	$2,370.85	$2,254.53	-4.91%
Total HFS Liability [1] ($ Millions)	$1,851.84	$1,838.12	$1,740.66	-5.30%
Total Patient Days ($ Millions)	18.5	19.15	17.94	-6.32%
Weighted Average Rate [2] Per Diem	$100.09	$96.00	$97.02	1.06%
Average Payment (Charge) Per Diem	$118.51	$123.80	$125.66	1.50%

[1]Reflects date of service liability.
[2]Excludes patient contributions and third-party payments.

Table Prepared By: Bureau of Rate Development and Analysis

Data Source: Bureau Rate Development and Analysis

Table III
Medical Assistance Program
Expenditures Against Appropriation
Fiscal Year 2012 -Fiscal Year 2014
Dollars in Thousands

	FY'12		FY'13		FY'14	
	Expenditures	**Percent**	**Expenditures**	**Percent**	**Expenditures**	**Percent**
Total [1,2]	**$9,128,608.1**	**100.0%**	**$11,576,777.4**	**126.8%**	**$10,493,490.9**	**100.0%**
Hospitals	**2,246,564.5**	**24.6%**	**4,222,599.6**	**46.3%**	**3,213,119.4**	**30.6%**
Long Term Care 3	**1,733,914.1**	**19.0%**	**2,120,445.8**	**23.2%**	**1,784,454.3**	**17.0%**
Practitioners	**1,260,642.4**	**13.8%**	**1,381,022.2**	**15.1%**	**1,434,926.3**	**13.7%**
Physicians	907,878.8	9.9%	1,101,322.5	12.1%	1,131,432.0	10.8%
Dentists	295,694.6	3.2%	233,014.0	2.6%	250,903.6	2.4%
Optometrists	47,450.5	0.5%	42,239.6	0.5%	48,220.9	0.5%
Podiatrists	8,217.8	0.1%	3,909.9	0.0%	3,966.8	0.0%
Chiropractors	1,400.7	0.0%	536.2	0.0%	403.0	0.0%
Drug	**1,880,529.9**	**20.6%**	**1,586,813.6**	**17.4%**	**1,418,893.4**	**13.5%**
Other Medical	**1,334,716.2**	**14.6%**	**1,428,645.7**	**15.7%**	**1,323,580.9**	**12.6%**
Laboratories	51,948.2	0.6%	77,520.7	0.8%	67,468.5	0.6%
Transportation	66,738.5	0.7%	83,255.0	0.9%	79,834.3	0.8%
SMIB/HIB/Expansion 4	389,452.8	4.3%	380,212.9	4.2%	399,248.3	3.8%
Home Health Care/DSCC	151,829.1	1.7%	163,604.9	1.8%	128,439.1	1.2%
Appliances	80,517.4	0.9%	94,308.1	1.0%	80,484.9	0.8%
Other Related 5	184,650.9	2.0%	164,042.5	1.8%	146,130.4	1.4%
Comm Health Centers	299,162.7	3.3%	290,847.8	3.2%	263,999.0	2.5%
Hospice Care	79,106.4	0.9%	114,932.9	1.3%	88,617.4	0.8%
Children's Mental Health Initiative/SIU ACR	31,310.2	0.3%	59,920.9	0.7%	69,359.0	0.7%
HMOs	**666,072.9**	**7.3%**	**832,343.3**	**9.1%**	**1,318,014.3**	**12.6%**
Children's Rebate	**6,168.1**	**0.1%**	**4,907.2**	**0.1%**	**502.3**	**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 Matching, Independent Academic Medical Center, Post-Tertiary Clinical Services, Money Follows the Person Budget Transfer, Electronic Health Record Incentive, Medicaid Buy-In, Medical Special Purposes Trust, and Juvenile Rehabilitation Services Funds.

2 Provider line expenditures include spending from the Healthcare Provider Relief Fund.

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

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

5 "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'14.

Table IV
Medicaid Providers
By Type of Service
Fiscal Year 2012-
Fiscal Year 2014

Provider Type	FY'12		FY'13		FY'14	
Hospitals						
Cost Reporting	240		236		243	
Therapists[1]	5,276		5,857		6,586	
Clinics[2]	799		781		831	
Long Term Care Facilities Total	1,160		1,097		1,271	
Nursing Facilities		732		678		831
ICF/MR		292		280		273
Supportive Living Facilities		136		139		143
SMHRF[3]						24
Physicians	43,151		44,682		47,764	
Dentists[4]	6,009		6,322		7,075	
Optometrists	1,015		1,109		1,188	
Podiatrists	634		651		690	
Chiropractors	567		573		587	
Nurse Practioners[5]	5,430		6,275		7,474	
Pharmacies	2,883		2,888		2,887	
Laboratories/Portable X-rays	525		560		637	
Transportation	2,036		1,564		2,090	
Home Health Agencies	454		450		446	
Managed Care Organizations[6]	5		5		7	
Hospice	116		121		127	
Durable Medical Equipment	1,591		1,571		1,611	
Community Health Agency	7		7		8	
Other Providers[7]	1,662		1,796		2,677	
Total Providers	**73,560**		**76,545**		**84,199**	

[1] Includes occupational, physical and speech therapists and audiologists.

[2] "Clinics" includes Ambulatory Surgical Treatment Centers, Encounter Rate Clinics, FQHCs, RHCs. Healthy Kids and hospital based Moms/Healthy Kids Clinics.

[3] Specialized Mental Health Rehabilitation Facilities.

[4] Reflects the number of dental sites available through the Department's dental contractor.

[5] Reporting nurse practitioners separate from "Other Providers" due to volume.

[6] Includes MCCNs.

[7] "Other Providers" consist of DORS schools, Early Intervention providers and optical companies.

TABLE V
Medical Assistance
Mandatory/Optional Services

FEDERALLY REQUIRED MEDICAL ASSISTANCE SERVICES PROVIDED IN FY 2014

ACA coverage for those 19-64 years of age
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 2014

Audiology services to non-citizens
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
Diagnostic services
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
Renal Services to non-citizens
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 2012 to 2014

	FY12	FY13	FY14	% Change FY12-FY14	% of Total Claims FY14
Total Claims Received	97,468,871	93,499,593	84,455,748	-13.4%	
Physicians	36,395,611	35,990,730	34,050,769	-6.4%	40.3%
Laboratory	2,226,043	2,093,168	1,922,559	-13.6%	2.3%
Transportation Services	2,173,410	2,012,903	1,792,646	-17.5%	2.1%
Medical Equip/Supply	2,200,533	2,028,600	1,885,495	-14.3%	2.2%
Health Agency	74,750	84,151	65,008	-13.0%	0.1%
Medicare	10,012,804	9,880,086	8,766,478	-12.4%	10.4%
Pharmacy	38,333,419	35,643,116	30,469,021	-20.5%	36.1%
Hospitals	5,214,796	4,947,218	4,763,053	-8.7%	5.6%
Long Term Care	746,919	756,556	674,469	-9.7%	0.8%
All Other Categories	90,586	63,065	66,250	-26.9%	0.1%

During fiscal year 2014, 84.5 million medical claims were received and processed by the Department. This was a decrease of 9.7 percent over the number of claims received in fiscal year 2013 and a 13.4 percent decrease over claims received during fiscal year 2012.

Of all the claims received in fiscal year 2014, approximately 80.4 million, or 95.2 percent were received via electronic transfer, virtually equal to the 95.1 percent in fiscal year 2013. ***Table VI*** above shows claims receipt history for fiscal year 2012 through fiscal year 2014.

Physician claims accounted for the largest share (40 percent) of total claims received during fiscal year 2014, with pharmacy claims (36 percent), Medicare (10 percent), hospitals (6 percent), and claims for labs (2+ percent) rounding out the top five receipt categories. Between fiscal years 2012 and 2014 and moving a portion of our Medicaid population to managed care, the slowest decreasing claims category was physicians showing approximately a 6 percent decrease, followed by hospitals decreasing by 9 percent and long term care claims decreasing by almost 10 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 2014, the PrePay Pricing Unit reviewed the reimbursement requests for 6.0 million services, 11.8 percent less than the number of services reviewed in fiscal year fiscal year 2013 and 12.4 percent less than the number services reviewed in fiscal year 2012. As a result of the PrePay Pricing Unit's review and pricing of claims, approximately $112.5 million in saving was realized by the Department in fiscal year 2014.

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** 631 **Expenditures** $2,111,536	• Respite care • Environmental modifications • Specialized medical equipment and supplies, • Medically supervised day care, • Placement maintenance counseling, • Nurse and family training	None	Renewal: No modifications or amendments

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** 295 **Served** 300 **Expenditures** $23,459,216	• Adaptive equipment • Assistive technology • Behavioral services • Residential habilitation	N/A	Amendment effective 01/01/14 increased waiver capacity from 280 to 295 individuals. Added ACA eligibility groups including adults age 19-64 without dependent children and income at or below 138% of the FPL; Former foster care young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits, eligible for services regardless of income and assets.

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:** 1,440 **Served** 1,426 **Expenditures** $17,998,162	• Home and vehicle accessibility modifications • Adaptive equipment • Assistive technology • Behavioral services • Service facilitation • Personal support • Caregiver training and counseling	• Temporary Assistance	Amendment effective 01/01/14 increased waiver capacity from 1,400 to 1,440 individuals. Added ACA eligibility groups included adults age 19-64 without dependent children and income at or below 138% of the FPL; Former foster care young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits, eligible for services regardless of income and assets.

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** 1544 **Served** 1,326 **Expenditures** $14,671,978	• 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	Amendment effective 01/01/14 increased waiver capacity from 1,542 to 1,544 individuals. Added ACA eligibility groups including adults age 19-64 without dependent children and income at or below 138% of the FPL; Former foster care of young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits, eligible for services regardless of income and assets.

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** 19,600 **Served** 19,386 **Expenditures** $647,741,420	• 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: • Amendment submitted in 2014 is pending federal CMS approval.

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** 4,905 **# Served** 3,764 **Expenditures** $65,645,618	• 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	Amendment effective 01/01/14 added ACA eligibility groups including adults age 19-64 without dependent children and income at or below 138% of the FPL; Former foster care of young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits, eligible for services regardless of income and assets.

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 19,032 Expenditures $265,035,401	• 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	Several amendments: 1) Two related to 1) ICF inclusion and clarification re. rate methodology; 2) Effective 01/01/14 increased waiver capacity from 35,498 to 37,728 individuals. 3) Added ACA eligibility groups including adults age 19-64 without dependent children and income at or below 138% of the FPL; Former foster care of young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits, eligible for services regardless of income and assets.

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 57,000 Served 59,345 Expenditures $466,505,755	• Homemaker, • Adult day services, • Personal Emergency Response System (PERS)	None	Several amendments: 1) In the Fall 2013, amendment modified service cost maximum ranges to equate to specific scores instead of a range of scores; 2) Amendment effective 01/01/14 increased waiver capacity from 48,675 to 57,000 individuals; added ACA eligibility groups including adults age 19-64 without dependent children and income at or below 138% of the FPL; Former foster care of young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits, eligible for services regardless of income and assets.

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** 8,9420 **Expenditures** $ 145,793,356	• 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	Integrated Care Program Medicare Medicaid Alignment Initiative ACA Adults

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
4 Our Kids (Illinois Health Benefits & All Kids Hotline)	1-866-468-7543
Client Eligibility- AVRS for Providers Only	1-800-842-1461 1-800-642-7588
TTY (for hearing impaired) *Handled by Next Talk*	1-877-204-1012
Client Eligibility – AVRS for Clients	1-855-828-4995
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 in connects to the Illinois Health Benefits and the All Kids Hotline).	1-877-543-7669

As of June 30, 2014, the Health Benefits/All Kids and the Drug Prior Approval Hotlines had received and handled over 655,000 calls from clients and providers. The Health Benefits/All Kids hotline responded to over 392,000 calls and the Drug Prior Approval/Refill Too Soon Hotline answered almost 264,000 calls. The hotline staff also process prior approval/refill too soon/4 script limit requests received via facsimile. In this same time period, over 200,000 requests were entered for review by pharmacy staff.

Back Cover

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

1) *305 ILCS 5/5-5* requiring the Department to report annually no later than the second Friday in April, concerning:

- "actual statistics and trends in utilization of medical service by Public Aid recipients,
- actual statistics and trends in the provision of the various medical services by medical vendors,
- current rate structures and the proposed changes in those rate structures for the various medical vendors, and
- efforts at utilization review and control by the Department of Public Aid."

2) *305 ILCS 5/5.8* requiring the Department to report annually to the General Assembly, no later than the first Monday in April, in regard to:

- "the rate structure used by the Department to reimburse nursing facilities,
- changes to the rate structure for reimbursing nursing facilities,
- the administrative and program costs of reimbursing nursing facilities,
- the availability of beds in nursing facilities for Public Aid recipients, and
- the number of closings of nursing facilities and the reasons for those closings."

3) *20 ILCS 2407/55* requiring the Department to report annually on Money Follows the Person, no later than April 1 of each year in conjunction with the annual report, concerning:

- "a description of any interagency agreements, fiscal payment mechanisms or methodologies developed under this Act that effectively support choice,
- information concerning the dollar amounts of State Medicaid long-term care expenditures and the percentage of such expenditures that were for institutional long-term care services or were for community-based long-term care services, and
- documentation that the Departments have met the requirements under Section 54(a) to assure the health and welfare of eligible individuals receiving home and community-based long-term care services ."

4) *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.

5) *305 ILCS 5/5-1.1, 5/5-1.4, 5/5-2* Requiring the Department to report to the General Assembly as part of the Medical Assistance Annual Report the status of applications for long term care services as a result of *Public Act 98-0104*.

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.