Bruce Rauner, Governor
Felicia F. Norwood, HFS Director

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

Fiscal Years 2013, 2014 and 2015

April 1, 2016

ILLINOIS DEPARTMENT OF Healthcare and Family Services

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To the Honorable Bruce Rauner, Governor

And Members of the General Assembly:

On behalf of the Illinois Department of Healthcare and Family Services, I present the Annual Report of the Illinois Medical Assistance Program. This 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 provides details on specific programs, participant numbers, and provider reimbursement. Information on the Department of Healthcare and Family Services' Medical Assistance Programs for fiscal year 2015, 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 2015 in compliance with reporting requirements.

I hope you find this report informative and useful as we work together to continue providing accountable healthcare services that are quality driven and fiscally sustainable to Illinois' most vulnerable populations.

Sincerely,

Felicia F. Norwood
Director

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I. OVERVIEW

The Department of Healthcare and Family Services ("the Department or HFS"), Division of Medical Programs, administers and, in conjunction with the federal government, funds medical services provided to approximately 25 percent of the State's population. In Fiscal Year 2015, Medicaid, and the medical programs associated with it, provided comprehensive health care coverage to over 3.2 million Illinois residents and partial benefits to 16,440 individuals.

The Department's programs currently cover approximately 3.2 million enrollees, including almost 1.5 million children, 195,102 seniors, 252,313 persons with disabilities, 635,972 federal Affordable Care Act (ACA) eligible adults, 631,126 non-disabled, non-senior adults and 16,440 enrollees with partial benefit packages. 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 expanded coverage resulting from the ACA.

Comprehensive Benefits	**FY 2013**	**FY 2014**	**FY 2015**
Children	1,647,167	1,572,082	1,516,769
Disabled Adults	266,419	254,091	252,313
Other Adults	713,402	657,578	631,126
Seniors	181,449	190,575	195,102
ACA Newly Eligible Adults		468,523	635,972
All Comprehensive	2,808,437	3,142,849	3,231,282
All Partial Benefits	86,083	67,651	16,440
Grand Total All Enrollees	**2,894,520**	**3,210,500**	**3,247,722**

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 2015, the Department spent approximately $17.9 billion (all funds), of which $12.15 billion was GRF/GRF like funds, on enrollee health benefits and related services.

II. THE FUTURE OF MEDICAID – TRANSFORMATION

As the largest insurer in Illinois and a department accountable to the people of our state, HFS is committed to ensuring quality healthcare coverage at sustainable costs. To continually advance our mission, the agency is embarking on a series of transformation initiatives. These innovative program improvements seek to achieve the critical objective of paying for quality, value and outcomes.

Guiding Principles

This transformation agenda is guided by a number of core principles. It is recognized that these goals must be pursued within the context of budgetary realities, as well as the rules, regulations and laws that govern the program. Among these principles:

- Beneficiaries should receive the right care, at the right time, at the right cost
- Care should be holistic – integrating the physical and mental health needs of beneficiaries
- Care should be evidence-based to deliver the best quality at the lowest cost
- Pay for what works to improve and maintain health and stop paying for what doesn't work
- Transform health care from a system that reacts after someone gets sick to a system that focuses on prevention and keeping beneficiaries healthy
- Prevent chronic disease whenever possible and coordinate care to improve quality of life and reduce chronic care costs
- Enable seniors and people with disabilities to live in their homes or community-based settings, instead of a higher-cost setting like a nursing home

Managed Care and Care Coordination

The Public Aid Code was amended in 2011 to mandate that at least fifty percent of all full benefit beneficiaries be in some form of risk based care coordination by January 1, 2015. Effective managed care expansion has been central to HFS planning and FY 2015 commenced a focus on not just managed care migration, but managed care transformation.

Managed care offers a way to deliver better Medicaid services with the promise of reduced costs. At the beginning of 2015, just over 50 percent of Medicaid clients were part of managed care programs. Today, more than 60 percent of beneficiaries are in risk-based managed care plans and by June 1, 2015, that number will surpass two-thirds.

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 objective, HFS began the implementation of a significant change that will be become the centerpiece of its Medicaid transformation – the alignment of Managed Care Organizations with ACEs and CCEs.

This transformation in care coordination will save the taxpayers money, while providing better care. Managed Care Organizations offer superior risk, quality management and analytics, while ACEs and CCEs offer vital clinical, community and frontline expertise in helping to serve our most vulnerable citizens. The resulting alignment will be stronger, fiscally sustainable entities that are better positioned to deliver quality, value and outcomes to the over 2 million enrollees in coordinated care programs.

Technology

In addition to Managed Care, technology initiatives are an essential part of HFS' Medicaid transformation agenda. The systems changes completed and advanced in 2015 will allow us to achieve the programmatic and financial objectives of the Medicaid program.

A. Integrated Eligibility System (IES)

HFS, in collaboration with the Department of Human Services (DHS), is in Phase II of its implementation of 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). 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 match rate that the federal government adopted to accelerate the development of systems to facilitate implementation of the Affordable Care Act (ACA) by states. The federal government offers a 90 percent match on the costs of the new system attributable to Medicaid. A small fraction of the costs are being covered by the U.S. Department of Agriculture, which administers SNAP. Overall, it is anticipated that Federal revenue will offset most of the cost of this long-overdue modernization.

B. New Medicaid Management Information System (MMIS)

The Department's current MMIS 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 increasingly more challenging to

maintain. With transition of the Medicaid program to managed care, a new system is critical to support the demands of the new Medicaid program.

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.

The first two phases of the IMPACT project have been successfully implemented. The e-MIPP system implementation occurred November 15, 2013. The Provider Enrollment system implementation launched July 20, 2015. HFS continues to enroll and validate some 300,000 providers that participate in the Medicaid program.

The full implementation of the cloud enabled MMIS is expected to occur by the end of 2018.

C. New Pharmacy Benefits Management System

HFS continues to work towards successful implementation of a new Pharmacy Benefits Management System (PBMS). The PBMS, Software as a Service Solution, has been certified by the Centers for Medicare and Medicaid Services (CMS). The new system will provide the Department with an Internet-based application capable of interacting with providers, manufacturers, and other stakeholders to conduct the business processes of managing the Pharmacy Services and Drug Rebate programs.

The PBMS project is a two-phase project: Phase 1 delivered implementation of the Drug Rebate solution and Phase 2 will bring implementation of Point-of-Sale and other ancillary components such as e-Prescribing. Phase 1 was successfully implemented April 1, 2015. Phase 2 is scheduled to be implemented during the fall of 2016.

FY 2015 represented a year of significant change in the state's Medicaid program – as we moved from managed care migration to managed care transformation. We will continue to be vigilant to transform our healthcare delivery system for Medicaid beneficiaries and maintain a program that achieves the highest standards of program integrity for the taxpayers of the State of Illinois.

III. LONG TERM CARE

There are 703 nursing facilities (NFs) serving Medicaid beneficiaries in the State of Illinois. The monthly average number of beneficiaries served in NFs during fiscal year 2015 has remained around 56,000. The number of facilities serving our clients decreased slightly in 2015 (refer to Certification/Decertification topic below for more detail).

Appendix E, in Section XIV, compares Medicaid certified beds versus licensed beds in NFs and Appendix F shows long-term care total charges and liability on claims received for fiscal years 2013 through 2015. In an effort to provide alternatives to NF placement, the Department, in collaboration with the Departments on Aging and Human Services, also offered care through nine Home and Community-Based Services (HCBS) waiver programs which served over 100,000 people. For more information on the HCBS waivers refer to Section XIV, Appendix B.

Field Activity

The Department uses registered nurses and medical assistance consultants to perform LTC-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 programs prior to their certification for participation in the Medicaid Program comply with Administrative Code 146 Subpart B.

Following certification, field staff performs ongoing monitoring of SLP providers which include investigations of complaints received through the SLP Complaint Hotline, annual recertification and critical incident monitoring. NF reviews are conducted to ensure compliance and that documentation supports the delivery of care and services as reported on the minimum data sets (MDS). Staff also reviews 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 2015, one nursing facility (NF) and 37 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) voluntarily closed. All 37 ICD/IIDs that closed converted to Community Integrated Living Arrangements (CILAs). All residents were relocated to appropriate settings. Eight 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 (RUGS) that are used to calculate Medicare rates. The Department utilizes the RUGS as the rate-setting tool for the nursing component of the Medicaid NF payment.

The MDS Data Repository system is web-based and records are loaded to the Enterprise Data Warehouse as data is received from Federal CMS to a State shared web platform. The MDS Data Repository system currently stores 5,127,440 assessments for 518,750 residents. For fiscal year 2015, the system received and processed 1,102,686 new records, including admissions, quarterly updates, change of status, and discharge records for 197,820 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:

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

  In response to this, DHS has substantially reorganized its process for LTC case processing into two LTC hubs using specifically trained caseworkers to handle LTC processing of applications, redeterminations and changes. Additionally, DHS and HFS have created a data base of pending LTC applications. This combination of efforts and the extraordinary work of DHS management and staff have reduced the number of pending applications from over 10,000 in January of 2014 to 2,300 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 525 in February 2015. Applications pending more than 90 days have decreased from almost 6,000 in January 2014 to less than 800 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 IES.*

  The State is exploring both the technical and budgetary feasibility of incorporating more information into the online application system and working with the IES team to identify every opportunity to add increased usability for LTC applicants. In the interim, 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.

Additional changes are pending until 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.

Reimbursement

Reimbursement rates for LTC facilities are calculated based on three separate components - nursing, capital, and support - which 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 placed on the methodology used for determining rates of LTC 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 $128.46 on June 30, 2015

Effective January 1, 2014, the Department redesigned its nursing rate methodology as directed by Public Act 098-0104. This methodology is based on the Federal RUG-IV 48 grouper methodology and its use continued during FY 2015. The 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, 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 2015, these included the following:

- *New facilities* – Facilities that are new to the Medicaid program do not have an established rate. For the nursing and support components of the rate, these facilities are given the median rate for their geographic area. The facility's capital costs are used to determine the capital portion of the rate

- *Capital Exceptions* – Facilities that have increased building costs by more than 10 percent, in the form of improvements or additional capacity, may request an adjustment to the capital component of their facility's rate. Capital exceptions resulted in rate changes for 95 facilities in fiscal year 2015.
- *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 six homes.

Long Term Care Provider Assessment

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 nursing facility and ICF/MR 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. Funds generated by the Program are set forth below:

Fiscal Year	Nursing Facilities	ICFs/MR
2013	$196.6	$20.5
2014	$189.1	$19.1
2015	$186.5	$18.0

** In millions*

IV. 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 1915(c) 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.

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 2015, 9,353 unduplicated Medicaid eligible residents participated in the program. At the end of fiscal year 2015, there were 144 SLFs, with a total of 11,698 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 18 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.

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. See Appendix B for specific details regarding each waiver.

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.

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.

Money Follows the Person and Long-Term Care Rebalancing

Money Follows the Person (MFP) is a federal program that provides enhanced federal Medicaid matching funds for state expenditures on home and community-based services for Medicaid clients whom states transition from institutional to home or community-based settings. Illinois began transitioning participants through the MFP Program in 2009, and through June 2015, it has drawn more than $15,000,000 in enhanced federal funding through MFP.

Under the terms of the MFP program, States must use the enhanced funding to rebalance long-term care utilization to increase the home- and community-based services, and for systemic improvements to support that goal. During Fiscal Year 2015, the MFP Program transitioned 543 clients out of institutions and into their communities; in all, Illinois has completed over 2,000 MFP transitions since 2009. As a result of the success of MFP and other state rebalancing programs, Illinois Medicaid spending on institutional services has decreased from 70% percent of Medicaid long-term care service expenditures in 2009 to just over 55% in 2015.

The MFP Program has also led to important systemic changes to support these rebalancing efforts, and possibly instruct future rebalancing efforts. To aid with outreach and client referral, the State has created an MFP website with MFP marketing and outreach materials, including a web-based client referral form. To facilitate referrals and improve case tracking, the MFP program has begun using a Microsoft Customer Relationship Management application, which allows automated program referrals and improved reporting. To aid in the location of suitable housing for clients who wish to

transition—a task that the State has identified as a major impediment to transitions—the State implemented an online housing matching and wait list system, and sought and received housing funding for MFP clients through the US Department of Housing and Urban Development Section 811 supportive housing voucher program. In addition, the Department has provided rebalancing funds to the Department of Human Services' Division of Mental Health for bridge subsidies to help MFP clients with mental health conditions obtain housing.

Illinois continues to explore new ways to increase and improve MFP transitions, to continue its progress towards rebalancing its service delivery system. The State has created annual analyses of completed transitions, to identify factors that create a risk of re-institutionalization and factors that contribute to sustained residency in the community. The State also engages transition engagement specialists to conduct client outreach and to educate clients and providers on the MFP program. The State also expects MFP transition figures to be buoyed by ongoing efforts to implement consent decrees in two class action lawsuits – *Ligas v. Quinn* and *Colbert v. Quinn* – that were filed to increase client access to community placements.

As the State shifts its Medicaid program increasingly from a fee-for-service to a managed care model, the MFP program has adapted to take advantage of the shift. An incentive program has been created to encourage managed care organizations to support MFP transitions and the Department is collaborating with managed care organizations on information sharing.

Fiscal Year 2015 MFP Transitions

Population Group	# Transitions
Individuals who are Elderly	43
Individuals with a Physical Disability	41
Individuals with a Serious Mental Illness	23
Individuals with an Intellectual Disability	69
Colbert Class Members (cross population)	367
Total	543

LTC 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	$4,047,496,360	$1,870,323,894	46.21%
2013	$4,697,974,907	$1,937,032,337	41.23%
2014	$4,753,731,217	$2,047,212,673	43.07%
2015	$4,285,410,655	$1,904,597,533	44.44%

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.

Balancing Incentive Program

The federal Balancing Incentive Program (BIP), authorized by the Affordable Care Act, incentivizes States to increase access to home- and community-based Long-Term Services and Supports (LTSS). By participating in BIP, Illinois was able to capture an increase in federal Medicaid funding equal to two percent of its spending on LTSS from July 1, 2013, through September 30, 2015, for an estimated total of $90.3 million in additional federal funding. With this enhanced federal funding, Illinois is implementing three structural reforms required by the BIP: implementation of a No Wrong Door/Coordinated Entry Point protocol; the provision of Conflict Free Case Management services; and implementation of a Core Standardized Assessment tool.

HFS, in collaboration with sister agencies, has begun work towards all three BIP requirements. No Wrong Door/Coordinated Entry Point sites have been selected, and training plans are being designed. A Conflict Free Case Management Protocol was submitted to and approved by the federal Center for Medicare and Medicaid Services, and State agencies will collaborate over the next year to implement that protocol. The agencies have selected and customized a comprehensive, internationally recognized, instrument for use as Illinois' core standardized assessment tool. Implementation planning efforts are underway to pilot the tool before a statewide roll-out in mid to late 2016. In support of these BIP efforts, the State will develop informational materials, an expanded hotline, and a new long term services and supports website to help consumers better understand and connect with local community-based services.

As of June, 2015 Illinois had received approximately $80 million of its enhanced federal funding. Illinois continues to reinvest BIP funding for efforts to rebalance the State’system of long-term services and supports to allow more community-based options for Medicaid clients.

V. MATERNAL AND CHILD HEALTH PROMOTION

Improving the health outcomes of women and children 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 over 50 percent of all Illinois births and over 90 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 2016 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 data are summarized below:

- Based on Vital Records data (CY2011-CY2012 certified, CY2013 uncertified), total Illinois and Medicaid-covered deliveries among teens are decreasing. 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
2011	11,960	12,941	92.4%
2012	11,160	12,029	92.8%
2013	9,545	10,437	91.5%

*Less than 20 years of age

Source: Illinois Department of Public Health. Vital Records for CY2011 - CY2012 are certified. Data for CY2013 are provisional pending certification by the Illinois Department of Public Health. Covered deliveries are those where the recipient had full benefits on date of delivery.

- Based on certified Vital Records data for CY2011-CY2012, the LBW (≤2,500 grams) rate per 1,000 live births for the Medicaid enrolled had a non-statistically significant increase (97.25 to 98.71, respectively) and the total Illinois population had a non-statistically significant decrease (81.62 to 80.74, respectively). The Medicaid LBW rate is higher than the rate for the total Illinois population. The provisional CY2013 LBW rates should be reviewed once certified since there are

increased rates for both groups, with a much larger magnitude increase for Medicaid enrolled (81.44 Illinois, 107.10 Medicaid). (Enterprise Data Warehouse, 2015)

- Based on certified Vital Records data for CY2011-CY2012, the VLBW birth rate per 1,000 live births for the Medicaid population shows a non-statistically significant increase (17.94 to 18.66, respectively) while the total Illinois population had a non-statistically significant decrease (15.29 to 15.10, respectively). Data for CY2013 (14.61 Illinois, 18.44 Medicaid) should be reviewed once certified since the provisional data show decreases between CY2012 and CY2013 for both groups. (Enterprise Data Warehouse, 2015)
- While VLBW births represent approximately 1.5 percent of all Medicaid birth outcomes (CY2011-CY2013), they account for over 20 percent of total Medicaid covered birth costs (prenatal care, delivery, postpartum, and infant's first year of life). Conversely, normal births account for approximately 50 percent of total Medicaid birth outcomes and approximately 20 percent of total Medicaid covered birth costs (prenatal care, delivery, postpartum, and infant's first year of life). (Enterprise Data Warehouse, 2015)

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.

The data has shown the need for continued focus on providing needed prenatal, postpartum and family planning services that can improve 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 2016 are posted on the HFS Web site. HFS initiatives focused on improving birth outcomes are described below.

Illinois Healthy Women (IHW)

Illinois Healthy Women (IHW) was completely phased-out effective December 31, 2014. HFS launched IHW in April 2004 under an approved federal Section 1115 Medicaid Research and Demonstration waiver to provide a limited package of family planning (birth control) and related reproductive healthcare benefits for low-income women in Illinois who were not otherwise eligible for Medicaid. HFS opted not to renew the waiver because the Affordable Care Act (ACA) required all individuals to have minimum essential healthcare coverage and the law required all health plans to cover birth control services.

Under the ACA and the related expansion of Medicaid in Illinois, starting January 2014, women enrolled in IHW had the opportunity to obtain comprehensive healthcare coverage through either Medicaid or the Health Insurance Marketplace. To ensure a

seamless transition into affordable healthcare plans, HFS continued IHW through December 31, 2014 to allow a transitional year for IHW clients to obtain other healthcare coverage.

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 was requested and approved, allowing the CHIPRA grant to continue through February 2016.

The CHIPRA Quality Demonstration Grant focused on improving birth outcomes. A number of interventions were developed, including a prenatal minimum electronic data set and a prenatal care quality tool, both of which were pilot tested during 2015. Best practices for perinatal care transitions were distributed to HFS enrolled perinatal providers through a Provider Notice dated September 29, 2015. The Perinatal Education Toolkit, with materials for educating women about preconception, prenatal, postpartum and interconception care, was pilot tested during 2015 and is now available to any health career or social service provider in the state on the EverThrive Illinois website. A postpartum care study was conducted in partnership with the University of Illinois at Chicago and the findings are being used to consider policy and reimbursement changes to improve the number of women who receive a postpartum visit. 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. ILPQC completed projects focused on reducing early elective deliveries and improving the weight of infants at discharge from the NICU through nutrition and feeding initiative. Both projects demonstrated improvement. Projects implemented in 2015 included an initiative to improve the accuracy of 17 key variables on birth certificates, an initiative to improve outcomes of very low birth weight infants requiring resuscitation and stabilization by taking specific actions during the "golden hour", the first hour after birth, and a maternal hypertension initiative.

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.

The Otho S.A. Sprague Memorial Institute awarded HFS a grant to address the prevention and management of childhood obesity. Through these funds, during CY2015, HFS entered into a two-year grant agreement with the Illinois Chapter, American Academy of Pediatrics (ICAAP) to achieve improved health outcomes related to the prevention and management of childhood obesity. The project goal is to implement provider practice change to improve the quality of care for patients at risk of obesity and obesity-related chronic conditions through ongoing medical education and training on recommended clinical guidelines for evaluation and management of overweight and obesity. The term of the grant agreement with ICAAP is for 24 months beginning April 1, 2015, and concluding March 31, 2017.

VI. DENTAL PROGRAM

The HFS Dental Program, administered by DentaQuest of Illinois, LLC (DentaQuest), offers a comprehensive package of services to children, including preventative, diagnostic, and restorative services. 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. In addition, DentaQuest provides services aimed at ensuring participant access to care for medically necessary dental services such as provider recruitment and training, enrollee education and referral coordination, an interactive website and toll-free telephone systems.

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.

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 for whom they provide care, a School Exam Follow-up Form to be sent home with the student, and a referral plan for follow-up care. In addition, providers must submit a caries risk assessment code rating the oral health of each child examined to receive payment for each child who receives care in a school setting. The caries risk assessment codes indicate 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. 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.

Reimbursement

DentaQuest reimburses dental providers according to the Department's fee schedule, with weekly payments received from HFS based on DentaQuest's adjudicated claims.

During fiscal year 2015, payment for dental care totaled nearly $198 million. DentaQuest reported that 735,751 individuals under the age of 21 received almost 5.5 million dental services, for a total expenditure of approximately $156.3 million. For the same time period, 204,000 individuals ages 21 and over received over 1.5 million dental services for a total expenditure of approximately $41.3 million.

More information regarding the HFS Dental Program may be obtained on the Department's Dental Program webpage or by visiting DentaQuest at www.DentaQuest.com or calling 1-888-286-2447 for help in finding a dentist.

VII. CARE MANAGEMENT

In 2015, the Illinois Medicaid program moved strategically to greater risk based managed care. Care Coordination Entities (CCEs) for Seniors and Persons with Disabilities, and Children with Special Needs (CSN CCEs), Accountable Care Entities (ACEs) for children, their families, and Adults under the Affordable Care Act (ACA), and Managed Care Organizations (MCOs) developed collaborations to better serve beneficiaries

The Department initiatives include the following programs: Integrated Care Program (ICP), Medicare Medicaid Alignment Initiative (MMAI), and Family Health Program (FHP) while maintaining the Primary Care Case Management (PCCM) program in the non-mandatory counties of the State. These managed care models allow the Department to meet its 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 improve health outcomes. 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 or her health needs including physical, behavioral, and social needs.

ICP serves SPD individuals in five mandatory regions in Illinois which includes: the Greater Chicago Region, the Rockford Region, the Quad Cities Region, the Central Illinois Region, and the Metro East Region. The five regions consist of 30 counties throughout the state. The ten health plans serving the ICP population and their respective enrollment as of June 2015 are displayed in the table below.

Integrated Care Program Enrollment

HEALTH PLANS	JUNE 2015 ENROLLMENT
Aetna Better Health Inc.	29,642
IlliniCare health Plan Inc.	28,613

HEALTH PLANS	JUNE 2015 ENROLLMENT
Community Care Alliance of Illinois	8,975
Meridian Health Plan Inc.	10,723
Molina Healthcare of Illinois	5,591
Health Alliance Medical Plan	6,419
Blue Cross/Blue Shield of Illinois	6,955
Cigna HealthSpring of Illinois	4,474
Humana Health Plan	4,529
CountyCare	2,818
Total Health Plan Enrollment	**108,739**

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, mental 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 seniors and 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.

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

Integrated Care Team
Each health plan has a multidisciplinary integrated care team for enrollees identified as needing care management. The integrated care teams consist of clinical and non-clinical staff whose skills and professional experience complement and support each other in the oversight of enrollees' needs. Such teams consist of the enrollee, care coordinators, behavioral health care coordinators, community service liaisons and the enrollee's providers. Care team functions include conducting enrollee assessments,

developing an enrollee care plan in collaboration with the enrollee and their caregivers, and communicating and coordinating care in a manner that ensures the enrollees' physical and behavioral health needs are met. The decision of what type of health care the member receives is ultimately in the hands of the member as ICP was designed to empower members to be in control of their own health care.

Performance Measures
The contracts with the health plans contain several 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 days after receiving a mental health diagnosis; follow up with a provider within fourteen days after an inpatient discharge, and management of chronic illnesses such as diabetes with appropriate care.

Family Health Plan/Affordable Care Act (FHP/ACA)

On July 1, 2014, the FHP/ACA Program was phased in to replace the former Voluntary Managed Care (VMC) Program. The new FHP/ACA program is a mandatory program for children and their families as well as the newly eligible ACA adults. There are an estimated 1.5 million enrollees for the FHP/ACA program. The State contracts with Health Plans to manage the provision of health care for FHP/ACA clients. Health Plans refer to Managed Care Organizations (MCOs). MCOs include Health Maintenance Organizations (HMOs) and Managed Care Community Networks (MCCNs). HMOs are licensed by the Department of Insurance and MCCNs are provider-owned and governed entities that operate like HMOs, but are certified by HFS rather than Department of Insurance. Except for financial solvency and licensing requirements, HMOs and MCCNs have the same contractual requirements. In line with the goal of serving at least 50% of Illinois Medicaid recipients in a care coordination/managed care program by January 2015, the State's contracts require Health Plans to offer the same comprehensive set of services to HFS clients that are available to the fee-for-service population.

The FHP/ACA Program consists of nine Health Plans; three converted from the VMC program: Family Health Network, Inc. (FHN), Harmony Health Plan of Illinois, Inc. (Harmony) and Meridian Health Plan, Inc. (Meridian). The six new health plans include: Blue Cross Blue Shield of Illinois (BCBSIL), County Care Health Plan (CountyCare), Health Alliance Medical Plans, Inc. (HAMP), IlliniCare Health Plan, Inc. (IlliniCare), Aetna Better Health, and Molina HealthCare of Illinois, Inc. (Molina).

Enrollment figures for the FHP/ACA program are displayed in the table below.

Family Health Plan/Affordable Care Act Enrollment

HEALTH PLANS	JUNE 2015 ENROLLMENT
Aetna Better Health	137,297
Blue Cross Blue Shield of Illinois	179,660
CountyCare Health Plan	171,667
Family Health Network	215,930
Harmony Health Plan of Illinois, Inc.	174,663
Health Alliance Connect, Inc.	85,685
IlliniCare Health Plan, Inc.	176,346
Meridian Health Plan, Inc.	227,226
Molina Healthcare of Illinois, Inc.	90,752
Total Health Plan Enrollment	**1,459,226**

Care Coordination Entities (CCEs) and Accountable Care Entities (ACEs)

CCEs and ACEs, provider-organized entities, deliver care coordination services to the FHP, ACA, CSN and SPD populations. Nine ACEs and eight CCEs were operational during FY 2015 and received enrollment and PMPM care coordination fees under the managed care expansion process.

In order to reduce administrative inefficiencies, improve quality, and provide a more fiscally sound managed care program, ACEs and CCEs developed collaborations and aligned their care coordination models with risk-based managed care organizations in FY 2015. The number of HFS contracting entities for care coordination will be reduced from 30 to 13 by June 30, 2016.

Primary Care Case Management Program – Illinois Health Connect

Clients enrolled in Illinois Health Connect receive both care coordination and case management services from their PCP. Eligible clients that must select a PCP in Illinois Health Connect for their medical home include most children enrolled in All Kids, adults, and seniors and adults with disabilities in the non-mandatory counties. Under the expansion of managed care pursuant to Medicaid Reform law (P.A. 96-1501) during the fiscal years of 2014 and 2015, over 1.5 million Illinois Health Connect members in the five mandatory managed care regions were transitioned from the Illinois Health Connect program to managed care health plans or other care coordination entities. With this transition, the Illinois Health Connect membership decreased from roughly 2 million members prior to June 30, 2014 to almost 400,000 members as of June 30, 2015 in the non-mandatory counties.

The Illinois Health Connect 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, increase access to care, and to reduce unnecessary emergency room visits and hospitalizations through established medical homes. Before Illinois Health Connect was implemented, clients had great difficulty getting care from providers, making appointments, securing referrals for specialty care, clients often flooded and overwhelmed the HFS Client help lines for assistance and would merely receive paper print outs of providers that may see them for services. This frequently resulted in clients accessing care in ERs and other locations that were not the most appropriate setting for care did little to manage a client's overall health care needs and resulted in escalated costs for services.

As of June 30, 2015 there were almost 400,000 Medicaid clients in the non-mandatory counties. Illinois Health Connect remains the primary resource for individuals that are currently excluded (TPL, SSI, DCFS, DSCC, etc.) from mandatory participation in a managed care program. Currently, there are 320,000 Medicaid clients.

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

Medicare-Medicaid Alignment Initiative

The Department and the federal Centers for Medicare and Medicaid Services (CMS) jointly implemented the Medicare-Medicaid Alignment Initiative (MMAI). MMAI is a joint effort to reform the way care is delivered to clients aged twenty-one and over who are eligible for both Medicare and Medicaid Services (also called dual eligibles). MMAI became effective on March 1, 2014 and is a three-party contract between HFS, CMS and the MCOs serving the Greater Chicago and Central Illinois regions. The six MCOs serving the MMAI population in the Chicago Region are: Aetna Better Health, Blue Cross Blue Shield, CIGNA HealthSpring, Humana, IlliniCare and Meridian. Health Alliance Connect and Molina Healthcare initially served the MMAI population in the Central Illinois region in FY 2015. Health Alliance Connect ceased participation in the MMAI program at the end of calendar year 2015.

The managed care plans are responsible for coordinating and arranging for the provision of all Medicare and Medicaid covered services. Clients may voluntarily enroll in the program or the Department can passively enroll them into a health plan. The first voluntary enrollments into the program became effective in March 2014 with the first passive enrollments becoming effective in June 2014. Enrollment of clients residing in LTC facilities or receiving HCBS waiver services began in July 2014 and continued through December 2014. Community residents had been passively enrolled in the initial phase of implementation in 2014.

Covered Services
MMAI plans provide the full range of covered services under the Medicare and Medicaid programs. If either Medicare or Medicaid provides more expansive services than the

other program for a particular condition, type of illness, or diagnosis, the MCO must provide the most expansive set of services required by either program. The MCO may not limit or deny services to enrollees based on Medicare or Medicaid providing a more limited range of services than the other program.

Assessment of Needs

In the MMAI program, MCOs must use population- and individual-based tools and real-time enrollee data to identify an enrollee's risk level. These tools and data include, but are not limited to, a health risk screening and, if needed, a behavioral health risk assessment for all new enrollees within sixty days of enrollment; predictive modeling based on the availability of enrollee claims data; and surveillance data identified through referrals, transition information, service authorizations, alerts, Determinations of Need (DON) results, and families, caregivers, providers, community organizations, and plan personnel. Based on this analysis, all enrollees are stratified as low, moderate, or high risk, with associated levels of interventions for the care management program. The MCO is expected to complete health risk assessments (HRAs) for high and moderate risk enrollees within ninety days (or face-to-face HRAs within one hundred and eighty days for enrollees receiving HCBS waiver services or residing in nursing facilities on their effective enrollment date). The MCOs are expected to develop person-centered care plans or all MMAI enrollees within ninety days of enrollment (or within one hundred and eighty days for enrollees receiving HCBS waiver services or residing in nursing facilities on their effective enrollment date).

Integrated Care Team

All enrollees are assigned a care coordinator and have access to a person-centered Interdisciplinary Care Team (ICT) to assist in assuring integration of services and coordination of care across the spectrum of the healthcare system; assure appropriate and efficient care transitions, including discharge planning; assess the physical, social, and behavioral risks and needs of each enrollee; provide medication management; provide health education on complex clinical conditions and wellness programs; assure integration of primary, specialty, behavioral health, long-term support services, and referrals to community-based resources; assist in the development of a person-centered care plan within ninety days of enrollment; and more. The MCO must have a sufficient number of care coordinators with the background and training to serve low, moderate, and high-risk enrollees, with caseloads weighted and blended to meet overall caseload limits while taking into account the location of the enrollee. Additionally, all assigned care coordinators must have the appropriate experience and qualifications based on an enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

Performance Measures

The MMAI contracts include a combination of core performance measures established by federal CMS that are included in all demonstrations across the nation as well as state-specified performance measures selected for the Illinois demonstration.

Additionally, to ensure that MMAI enrollees receive high quality care and to incent MCO quality improvement both Medicare and Medicaid withhold a percentage of their respective components of the capitation rate. The federal CMS core withhold measures for demonstration year one are: members with initial assessments completed within ninety days of enrollment; establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements; percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed (on three specified AHRQ/CAHPS questions); encounter data for all services covered under the demonstration, with the exception of prescription drug event data, submitted timely in compliance with demonstration requirements; and percent of best possible score the plan earned on how quickly members get appointments for care (on three specified AHRQ/CAHPS questions). The Department-specified quality withhold measures for demonstration year one are: moderate and high-risk members with a comprehensive assessment completed within ninety days of enrollment; percent of enrollees with documented discussion of care goals; and plan has established and implemented Americans with Disabilities Act (ADA) compliance plan.

REIMBURSEMENT

Managed Care Organizations

Managed Care Organizations (MCOs) participating in the Department's Integrated Care Program (ICP), Family Health Plan (FHP)/Affordable Care Act (ACA) 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, health plan claims experience, and enrollment data. 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 different population rate cells, which are broken out based on the type of enrollee (community residents, nursing facility residents, enrollees in HCBS 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 nine quality metrics for HEDIS 2015 calendar year 2014 measurement. The incentive pool is funded through a withhold of a portion of the capitation rate, one percent in the first measurement year, 1.5 percent in the second measurement year, and two percent in the third 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 mental health, diabetes care, congestive heart failure, coronary artery disease, pharmacy, management to prevent worsening of chronic obstructive pulmonary disease (COPD), ambulatory care, follow-up care after inpatient discharge, and Emergency Department visits and utilization. For HEDIS 2015, Aetna Better Health did not meet any of the P4P measures but improved in six of the sixteen components of the P4P measures. IlliniCare met the Department's performance goal in three measures and improved in thirteen of the sixteen components of the P4P measures.

Family Health Plan/Affordable Care Act Program

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. Similar MLR and P4P measures apply to FHP, as described in the ICP section above.

Medicare-Medicaid Alignment Initiative

MMAI demonstration contracts are three-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 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.

The Medicare Parts A/B rate component and the Medicare Part D payment is risk adjusted using federal CMS models. To risk adjust the Medicaid component, the Department assigns each enrollee to a rating category according to the individual enrollee's age (21-64 or 65+) geographic service area (Greater Chicago or Central Illinois), and setting-of-care (nursing facility, waiver, waiver plus, and community, with three month plus rates for specified care transitions).

MMAI Shared Savings
Shared savings are built into the MMAI Medicare Parts A/B and Medicaid capitation rates in anticipation of improved care management and administrative efficiencies across Medicare and Medicaid, as shown below. The savings percentage is applied to the Medicaid and Medicare Parts A/B components of the rates; it is not applied to the Part D component of the rate. Data on cost-savings from the MMAI program is not yet available, as the first demonstration ended December 31, 2015.

Current MMAI Demonstration Years with Aggregate Shared Savings and Calendar Dates

MMAI Demonstration Year	Aggregate Shared Savings	Calendar Dates
1	1%	02/01/2014 – 12/31/2015
2	3%	01/01/2016 – 12/31/2016
3	5%	01/01/2017 – 12/31/2017

MMAI Quality Payment Withholds
To ensure that MMAI enrollees receive high quality care and to incent MCO quality improvement both Medicare and Medicaid withhold a percentage of their respective components of the capitation rate. The withheld amounts are repaid retrospectively subject to participating plan performance consistent with established quality requirements that include a combination of core quality withhold measures across all demonstrations nationally, as well as Department-specified quality withhold measures. The Department-specified quality withhold measures for demonstration year one are: moderate and high-risk members with a comprehensive assessment completed within ninety days of enrollment; percent of enrollees with documented discussion of care goals; and plan has established and implemented Americans with Disabilities Act (ADA) compliance plan.

Care Coordination Entities and Accountable Care Entities

Care Coordination Entities (CCEs), and Accountable Care Entities (ACEs) received a per member per month (PMPM) payment for care coordination services. ACEs received a care coordination fee of $9 PMPM for FHP members and $20 PMPM for ACA Adult members. PMPM care coordination fee for CCEs varied depending on the geographic region and the special population being served. Payment of monthly PMPM fees to ACEs and CCEs ceased December 31, 2015, resulting in savings to the state of roughly $30 million for FY 2016.

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 enrollees. 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.

VIII. MENTAL HEALTH SERVICES

Screening, Assessment and Support Services Program

Since 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 known 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 2015, the SASS program served 21,000 unique children and youth with an estimated cost avoidance of approximately $19 million per year to the State for unnecessary psychiatric inpatient hospitalization and related costs.

In state fiscal year 2015, HFS began the rollout of mandatory managed care for children and youth in Family Health Plan contracts as part of its mandate under PA96-1501 (also known as Medicaid Reform) to enroll 50% of the Medicaid population in a care coordination program by January 1, 2015. This shift in the Medicaid system impacted the SASS program, as children and youth enrolled in an HFS-contracted managed care plan are not eligible for participation in the SASS program. Thus, the SASS enrollment numbers cited above only reflect youth experiencing episodes of crisis in the fee-for-service system. Youth enrolled in a Family Health Plan contract now access their managed care plan's Mobile Crisis Response system, which is contractually required by HFS to minimally deliver the same basic service functions as a member would experience in the SASS program. Managed care plans serving these youth also continue to utilize the CARES line, ensuring the State's centralized single-point of entry and monitoring of timely response to crisis services. In support of these transitioning functions, HFS staff actively and continually provide technical assistance to all of the Family Health Plan contractors.

Psychiatric Consultation Phone Line — Illinois DocAssist

HFS, in collaboration with the Departments of Human Services' Division of Mental Health (DHS-DMH), 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/.

Additionally, beginning on January 1, 2015 Illinois DocAssist expanded its services to include consultation and education specific to perinatal behavioral health. DocAssist provides warm line consultation **Monday - Friday, 9:00 am – 5:00 pm** for Primary Care

Providers and other serving practitioners seeking assistance with the perinatal mental health needs of pregnant and newly parenting women they serve. Finally, the DocAssist team was tasked with the development and maintenance of a medication chart specific to perinatal depression which can be found on the following website: http://www.psych.uic.edu/docassist/Perinatal_Med_Chart_May_2015.pdf.

Psychotropic Medication Quality Improvement Project (PMQIC)

HFS, in collaboration with DCFS, and in partnership with the University Of Illinois School Of Psychiatry wrapped up the final year of its Psychotropic Medication Quality Improvement Project (PMQIC): "Improving the Use of Psychotropic Medications among Children in Foster Care," sponsored by the Center for Health Care Strategies (CHCS) and the Annie E. Casey Foundation. The PMQIC project has focused on: increasing the consent compliance on script writing for foster children; decreasing inappropriate requests for psychotropic medication for 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).

As PMQIC closes as a project, the Department hopes to leverage its efforts within the context of the larger Medicaid program for youth that receive psychotropic medication by reviewing and specifically considering the recommendations related to: managing requests for psychotropic medications for small children; the guidelines for second generation antipsychotics and maintenance pharmacotherapy; and the other quality indicators for youth proposed by PMQIC.

Medicaid Emergency Psychiatric Demonstration

Illinois was one of eleven states chosen by Federal CMS to participate in the Medicaid Emergency Psychiatric Demonstration (MEPD) – Section 2707 of the Affordable Care Act – which was implemented by HFS, in collaboration with DHS–DMH. The demonstration allowed the departments to develop targeted interventions to address the needs of Medicaid eligible adults experiencing a psychiatric emergency by partnering with select hospitals, emergency departments (EDs), and community mental health centers (CMHCs) in the Cook County area. Two (2) Community Connect Sites were established with each consisting of (1) hospital as well as (1) partnering ED and Community Mental Health Center (CMHC). These sites were established to provide a network of care coordination teams through targeted case management (TCM) to reduce ER psychiatric boarding, decrease recidivism, and increase the overall quality of service delivery to Medicaid participants presenting in a psychiatric emergency. The demonstration partners included: Chicago Lakeshore Hospital, Riveredge Hospital, Presence Behavioral Health, and Community Counseling Centers of Chicago. Each Community Connect team utilized Illness Management Recovery (IMR), a SAMHSA approved evidence-based practice, as a treatment framework to increase consumer

engagement and reduce psychiatric recidivism. The Illinois' Community Connect Program began serving participants in December 2012 and went on to serve a total of 315 individuals over the three (3) year demonstration. Throughout the life of the demonstration, the following occurred:

- In July 2013, CMS determined that Illinois had the capacity to increase admissions in the Demonstration. This was largely due in part to the lack of spending in MEPD as a whole. CMS anticipated Illinois adding an additional IMD to Community Connect and increasing enrollments in year two. HFS did not pursue this option due to administrative and infrastructure challenges.
- In July 2014, CMS notified HFS that Medicaid expansion states would be allowed to receive Federal match at 100% of the Federal Medical Assistance Percentage (FMAP) for demonstration enrollees who are newly eligible for Medicaid under the Affordable Care Act (ACA). This enhanced match rate was eligible for participants from July 1, 2014 through the end of the demonstration.
- In March 2015, HFS discontinued new enrollment into the MEPD program to allow all enrollees ample time receive a full course of treatment through the active period of the Demonstration. The Department's rules related to MEPD expired on June 30th, 2015.
- The Federal Government was still working with all 11 MEPD sites to determine the potential impacts of a program extension, at the time this report was being prepared.

Choices Coordinated Care Solutions

In conjunction with the other care coordination efforts being undertaken by HFS, the Illinois Choices Demonstration Project was established in fiscal year 2015. The Choices Demonstration Project is designed to pilot an alternative approach, rooted in the System of Care philosophy, aimed at serving children and youth with significant behavioral health needs. The Demonstration offers a tiered model of intensive care coordination focusing on behavioral health services management for Medicaid-eligible children in Champaign, Ford, Iroquois, and Vermilion counties. Choices enrollees are in the state's fee-for-service system and have access to all HFS-enrolled medical providers. Choices is reimbursed for care coordination through a monthly care coordination fee and also has access to a funding line called the Demonstration Risk Pool (DRP) for the purposes of purchasing alternative services and alternative modes of service delivery for their enrollees.

In addition to developing a care coordination model for the youth served in this area, Choices is contractually required to implement Mobile Crisis Response Services in the four county area and develop new enhancements to mobile crisis response services to the youth served in that area. It is anticipated the new Mobile Crisis Response model established by Choices will assist the Department in considering future enhancements to the State's legacy Screening, Assessment, and Support Services (SASS) program. Anticipated enhancements include: requiring a higher-level practitioner perform the

crisis screening; emphasizing team-based crisis intervention when appropriate; and the introduction of additional crisis supports, such as crisis stabilizers – to assist children and families avoid common and recurrent “hot spots” or triggers events by providing short-term supports during moments that often cause families the most stress leading to crisis.

In their first year of operation, Choices completed a quality improvement project focused on educating the community and providers on Systems of Care. Additionally, Choices has worked collaboratively with HFS to invest in peer support in the four-county area, ensuring this service will be available to its enrollees in the future. Choices has established several necessary feedback mechanisms in the form of committees, including: Stakeholder’s Committee, Family Leadership Council, and Quality Management Committee. Family participation is encouraged at all committees and events and Choices continues to work to develop stronger family voice in the four-county area.

IX. HOSPITAL PROVIDER REIMBURSEMENT

260 hospitals participated in the Illinois Medicaid program in FY 2015.

Hospitals are reimbursed in several ways, including:

- Inpatient Claims
- Outpatient Claims
- Disproportionate Share Hospital Payments
- Static Payments
    - Hospital Assessment Funded Supplemental Payments
    - GRF Funded Supplemental Payments

The payment and utilization data presented in this section and the outpatient section that follows are limited to those individuals covered under fee-for-service reimbursement and does not include those covered under a Medicaid Managed Care plan. With the transition of individuals from fee-for-service and into managed care plans, a reduction of fee-for-service utilization and spending from 2014 to 2015 is expected. Also, these sections do not include data from the large government owned or university owned hospitals that provide a portion of the state's share of reimbursement nor does it include hospital payments that are partially funded through hospital assessments.

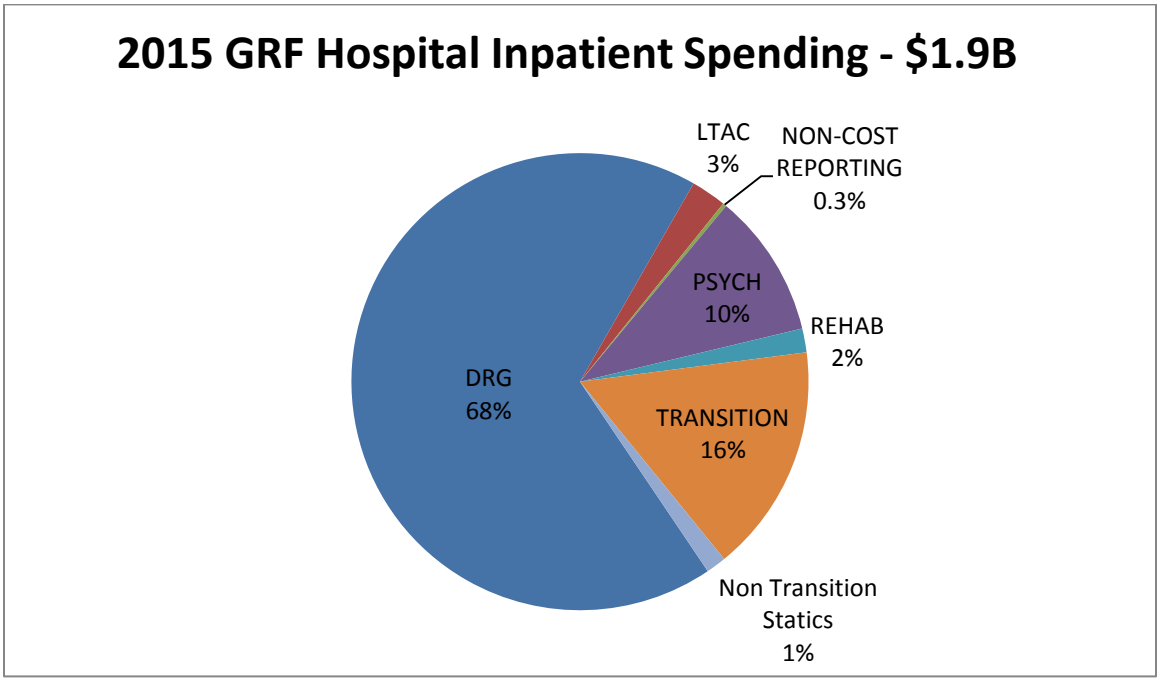
Inpatient Hospital Services - General Revenue Fund (GRF)

Inpatient hospital claims consist of APR-DRG (All Patient Refined Diagnosis Related Groups) acuity based groupings with various specialized claims based add-ons, including Disproportionate Share, safety-net, psychiatric, Medicaid Percentage Adjustment and Medicaid High Volume Adjustment.

Total hospital inpatient liability, including payments for both claims and GRF-funded static payments, totaled $1.9 billion, a 17% drop from the $2.3 billion spent in 2014. This corresponds with a 17% reduction in general acute care admissions. The reductions in utilization and overall payments are directly tied to the movement of individuals into managed care. Of the nearly $400 million reduction in inpatient payments, only $30 million is attributable to a reduction in static payments, from $360 million to $330 million, and the remaining $370 million is due to the lower utilization levels.

As shown in the graph on the following page, nearly 70 percent of the $1.9 billion in state fiscal year 2015 hospital inpatient payments were made pursuant to the APR-DRG based system that was implemented July 1, 2014. That is up from 50 percent in fiscal year 2014 in large part due to the children's hospitals and a handful of other acute care hospitals that were reimbursed under a per diem methodology in years prior to 2015, now being reimbursed under the APR-DRG system. Some services continue to be paid on a per diem basis, excluded from the APR-DRG, including psychiatric and

rehabilitation, as well as services provided by long term acute care hospitals and non-cost reporting hospitals.



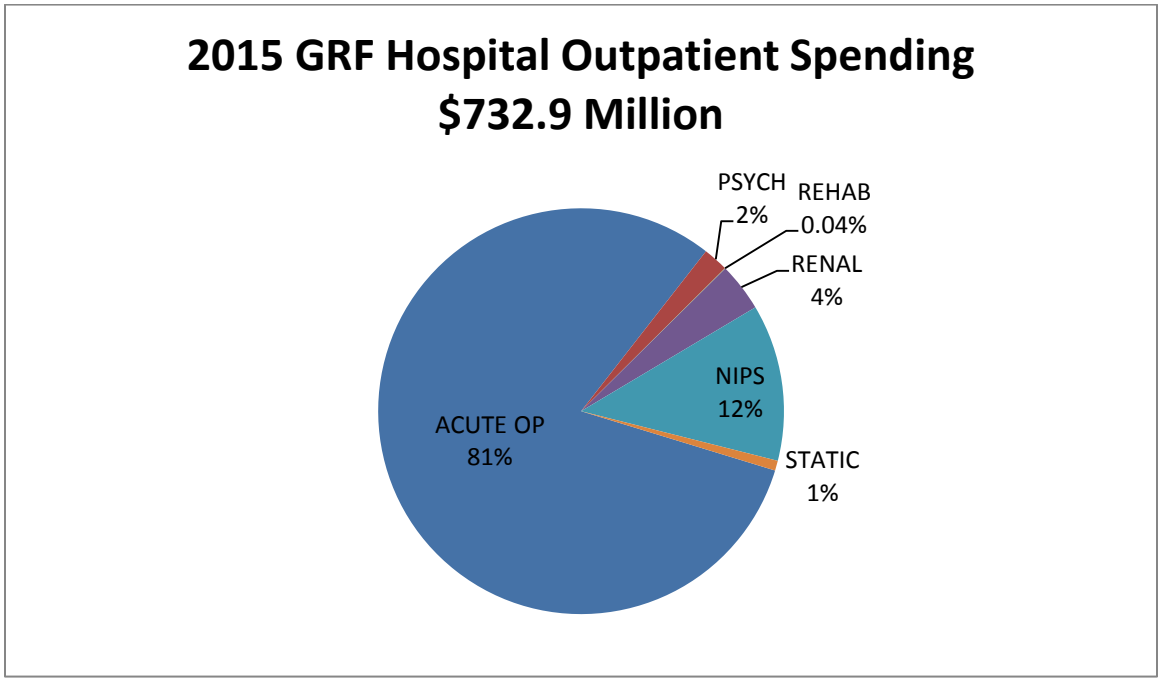
Outpatient Hospital Services – GRF

Ambulatory Care Services
Effective July 1, 2014, the Department replaced the antiquated fee-for-service, ambulatory procedure listing (APL) outpatient reimbursement system with the Enhanced Ambulatory Procedure Grouping (EAPG) reimbursement system. This was a monumental change in the reimbursement systems, going from a format of paying based on the single highest paid procedure code on the claim, to paying on multiple procedures that are billed on the same claim. The EAPG system works much like a DRG system on the inpatient side, assigning like procedure codes to an EAPG group and assigning relative weights to the EAPG groups based on national averages of resource consumption to provide the services. This new system allows hospitals to be paid for multiple procedures on one claim and also incorporates discounting and consolidation of payments when appropriate.

While the movement to managed care resulted in the reduction of outpatient claims by 13%, from 3.1 million in 2014 to 2.7 million in 2015, there was a 24% increase in outpatient claim based reimbursement. Total 2015 spending on institutional claims paid via the EAPG system was $600 million, up from the $490 million spent under the older APL system in 2014. This increase is the direct result of changes made under the hospital rate reform initiative. First, $40 million of the outpatient static payments in 2014 were eliminated and moved into the outpatient rates. The addition of $40 million to the 2014 APL liability lowered the overall increase to 14%. Second, to offset historic

inequities between the inpatient and outpatient rates of reimbursement and to further incentivize the use of the outpatient setting, when developing the new outpatient rates, the Department shifted $155 million of historical inpatient funding to the outpatient rates.

The chart that follows displays the total 2015 hospital outpatient spending including claims reimbursed through the EAPG, renal claims, non-institutional claims, and the small amount of outpatient static claims that remain. Again, the acute psych and rehab claims payment reimbursed through the EAPG make up 83% of the total payments. In 2014, outpatient non-claim specific, static payments accounted for 7% of outpatient payments which has been reduced to 1% in 2015.



Non-GRF Funded Hospital Payments

Provider Assessment and Hospital Access Improvement Payments
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 hospital 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.

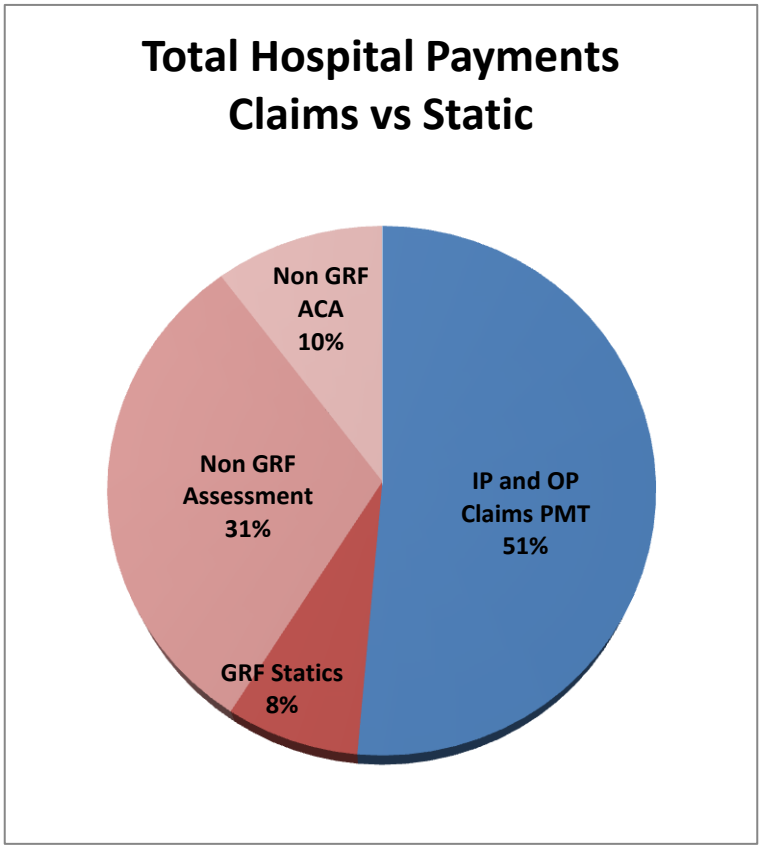
Fiscal Year	Hospital Assessment*

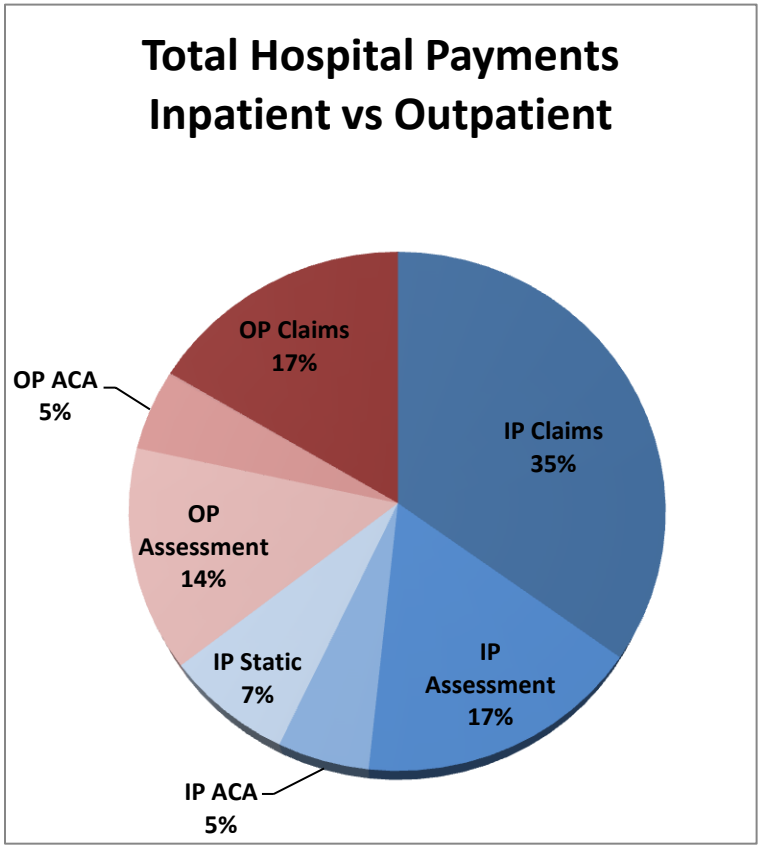
2013	1,196.2
2014	1,180.8
2015	1,209.2

In accordance with Public Acts 95-0859, 97-0688, and 98-0104, the Department is authorized to make hospital access improvement payments to qualifying hospitals. Instead of the state's portion of the payments being funded through the general revenue fund, these payments utilize funding garnered through both an inpatient and outpatient assessment on Illinois hospitals. In total, nearly $2 billion in payments are made to the hospitals through both fee-for-service payments and managed care capitation rates. In 2015, $1.35 billion was paid in fee-for-service payments with $1 billion attributed to inpatient services and $350 million to outpatient services.

Affordable Care Act (ACA) Payments

The Department was granted approval by CMS to increase the current Hospital Access Payments to account for those persons that are newly eligible under the Affordable Care Act (ACA). Currently, payment for services provided to these individuals is 100% funded by the federal government. Inpatient and outpatient quarterly payment pool amounts are determined based in part by the actual fee-for-service utilization data attributable to the newly eligible and distributed monthly in the following quarter. In state fiscal year 2015, over $496 million was paid to hospitals in the form of ACA payments.





Disproportionate Share Hospitals (DSH)

Federal law requires hospitals that serve a disproportionate number of low-income patients with special needs be given an appropriate increase in their inpatient rate or payment amount. Additionally, 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 2015, 78 hospitals qualified for the DSH adjustment with a total spending of $5 million. In addition, three state-operated psychiatric hospitals qualified for DSH because their low-income utilization rate exceeded 25 percent. DSH spending to the state operated psychiatric facilities was $89.3 million in federal fiscal year 2015 and the University of Illinois was paid $36.5 million. The average DSH payment for hospitals other than state operated psychiatric facilities and the University of Illinois was $20.56 per DSH day in fiscal year 2015, an increase of over 320% from the $6.39 per DSH day paid in fiscal year 2014.

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. Fifty-eight hospitals qualified for DSH payments in 2015, 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.

X. 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 controls access to 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 2015, the reimbursement rate for single-source medications (i.e., brand name) was Wholesale Acquisition Cost (WAC) or State Maximum Allowable Cost (SMAC) plus a dispensing fee of $2.40. Multi-source medications (i.e., generics) were reimbursed at WAC, SMAC, or Federal Upper Limit (FUL) plus a dispensing fee of $5.50. The Department's maximum price for each drug continues to be the lesser of WAC, the FUL, the SMAC, or the pharmacy's usual and customary charge.

The Department continued to contract with Goold Health Systems to develop and maintain a comprehensive listing of accurate SMAC reimbursement rates. 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

The Four Prescription Policy requires that participants obtain prior approval for prescriptions after they have filled four prescriptions in the preceding 30 days. 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 continued to identify 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.

Specialty Drug Use

The Department has 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, cystic fibrosis medications and oncology agents. The goals of the specialty drug utilization controls are to encourage the use of the most cost effective medications where clinically appropriate, and ensure utilization is consistent with treatment guidelines.

Hemophilia Care Management Program

Through the Department's Hemophilia Care Management Program, quality and utilization control initiatives for patients with hemophilia receiving blood factor continue to prove effective. As a part of this program, pharmacies must sign a Standards of Care Agreement (SOCA) in order to dispense blood factor to Medicaid participants. In addition, the Department continues to require prior approval for blood factor products to ensure proper utilization. Further information can be found on the Department's website.

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 does not report third party payment on a pharmacy claim, the claim rejects instructing the pharmacy to bill the third party first. For dates of service during FY15, $43.4M in third party payments was reported on pharmacy claims. This is an increase from the $36.9M reported on claims with dates of service during FY14. For dates of service during FY15, the calculated third party payment per prescription was $3.21. This is an increase from the $2.28 the calculated third party payment per prescription during FY14.

Drug Prior Approval System

The Department employs a web-based drug prior approval system. The system allows 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 status of their requests.

Drug Rebate Program

The drug rebate program which is mandated under the federal Omnibus Budget Reconciliation Act of 1990 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. As part of the In PDL development process, The University of Illinois at Chicago's College of Pharmacy performs the clinical analysis for 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 PDL proposals 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 2015, the Department collected approximately $11.5 million in state supplemental rebates from drug manufacturers.

XI. 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 274,000 Illinois school children participating in the School-Based Health Services program received direct medical services during fiscal year 2015. Local Education Agencies received reimbursement of more than $115.7 million for their costs to provide these services and more than $51.4 million for their administrative costs. For more information visit: <http://www.sbhsillinois.com/>

XII. REIMBURSING OTHER PROVIDERS

Rural Health Clinics (RHCs)

The RHC program, which has existed in Illinois for approximately 40 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 2015, the RHC program had 233 sites in Illinois. This reflects a decrease of seven 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 2015, medical encounter rates for RHCs ranged from $48.12 to $92.70 and behavioral health encounter rates ranged from $53.35 to $63.98.

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 2015, there were 389 FQHC sites throughout Illinois. This reflects an increase of three sites from fiscal year 2014. As with RHCs, FQHCs are also reimbursed a PPS based encounter rate. In fiscal year 2015, medical encounter rates for FQHCs ranged from $117.16 to $137.56 and behavioral health encounter rates ranged from $38.18 to $55.96.

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 the necessary standards and controls to ensure that the payment for transportation services complies with federal requirements.

The program ensures that

- transport is to a covered medical service;
- transport is via the most cost effective mode, meeting the medical needs of the participant, and;
- the participant is being transported to the closest appropriate medical provider.

The program is currently administered by First Transit, Inc. They are responsible for the screening and prior authorization adjudication process for all non-emergency medical transportation. During the fiscal year 2015, the program processed 413,728 non-emergency transportation transactions. The reduction in NETSPAP transactions processed between 2014 (516,542) and 2015 is due to the transition of Medicaid participants to care coordination entities.

XIII. 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 allowed the CHIPRA grant to continue through February 2016. During the extension period, HFS worked on improving and sustaining many CHIPRA accomplishments.

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.

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. The PMEDS tool is being pilot tested to determine its efficacy.

Enhancing the Delivery System - Patient-Centered Medical Homes (PCMH)
The CHIPRA PCMH/Asthma Learning Collaborative kicked off in May 2014 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 was released in 2015. Three practices received consultation and technical assistance through the CHIPRA grant in applying for PCMH recognition from the National Committee on Quality Assurance. One practice achieved Level 3, the highest level of recognition. The other two practices continued to work on recognition with consultation and technical assistance being provided as needed. This work resulted in a toolkit to assist practices through the recognition process. The April 2014 CHIPRA report, "Recommendations on incentives to promote the voluntary adoption of medical home principles by HFS' providers of primary care services to children: Position Paper," has be widely circulated to spur interest in practice transformation.

Managed Care - External Quality Review Organization

Federal regulations (42 CFR Part 438 Subpart E) require that specific review activities be performed on MCO's by an External Quality Review Organization (EQRO). HFS engaged in a competitive procurement process and contracted with Health Services Advisory Group (HSAG) for a three year term from January 1, 2013 thru December 31, 2015, with three one-year options. HSAG provides federally-required External Quality Review activities which include: readiness reviews for new plans prior to implementation, quality oversight and monitoring of waiver providers through record review audits of enrollee care plans for all health plans, monitoring the quality of services and supports provided to Home and Community Based Services (HCBS) program enrollees, as well as providing technical assistance to health plans. This includes all care coordination programs developed by HFS, such as the Integrated Care Program (ICP), Voluntary Managed Care Organizations [transitioned to Family Health Program/Affordable Care Act (FHP/ACA) health plans July 1, 2014], the Medicare-Medicaid Alignment Initiative (MMAI), Care Coordination Entities (CCEs), Accountable Care Entities (ACEs), and other programs developed under the Department's Innovations Program. HSAG also performs a separate annual 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.

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 the Centers for Medicare & Medicaid Services (CMS).

Consistent with its mission, HFS has identified the following 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: Integrated Care Delivery– the right care, right time, right setting, right provider.
- Goal 4: Ensure consumer safety, satisfaction, access to, and quality of care and services delivered to Illinois Medicaid recipients in select Care Coordination and 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 (EQR) 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.

Utilization Review & Quality Assurance - Inpatient, Fee for Service

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, Inc., 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 FY15, non-certification of medically unnecessary services resulted in direct cost savings of $16.2 million for a cumulative savings exceeding $297 million since 2002. The FY15 return on investment is $2.85 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
The quality of care rendered is evaluated to ensure that professionally recognized standards of care are met. When potential quality concerns are identified, the nurse reviewer refers the case to a physician reviewer. In FY15, eQHealth's utilization review coordinators referred 345 potential quality concerns. Physician reviewers concurred with 228 (66.1%) of the referred quality concerns.

Review Activity/Volume

- Concurrent and pre-payment reviews

  In fiscal year 2015, eQHealth conducted 165,478 concurrent and prepayment reviews associated with 103,131 hospitalizations. Compared to FY14, the volume of hospitalizations increased by 0.1%; whereas, the total review volume decreased by 6.6%. A total of 16,383 child and adolescent psychiatric hospitalization reviews were performed which represents 20.5% of the total volume of all hospitalizations concurrently reviewed. The children's mental health population represents over 20% of all hospitalizations reviewed.

- Post-Payment reviews

  During fiscal year 2015, 5,601 post-payment reviews were conducted which is down from 6,308 post pay reviews conducted last fiscal year.

- Post-Payment reviews

  During fiscal year 2015, 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 2015, a total of 12,478 reviews were referred to physician reviewers for additional evaluation representing 7.5% of reviews conducted. The FY15 denial rate was 21.3% which is up from 18.5% in FY14. A denial is defined as a review referred for medical necessity that has one or more days non-certified. Of notable interest, 9% involved admission denials and 12% were length of stay denials.

- Post-Payment

  During fiscal year 2015, 239 reviews were referred due to a failed quality screen. It should be noted that one referral can include multiple failed quality screens, and the physician reviewer addresses each failed quality screen individually. First level physician review determined 176 failed screens had at least one quality concern of a minimal, moderate, or serious risk. Moderate and serious quality concerns represented 47.7% 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 11,696 detox reviews were conducted, 547 (4.7%) reviews were referred for physician review, with a denial rate of 26.1%.
- Medically unnecessary cesarean sections – eQHealth evaluates the medical necessity of all 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. An unexpected outcome of this initiative has been the consistent lack of provider response to medical record requests. The provider non-response rate represents 10.8% of the sampled population. During FY15, 6,587 cesarean deliveries were reviewed, 429 records were referred for physician review, and 86 cases were determined to be medically unnecessary.
- Prior authorization of Coronary Artery Bypass Graft (CABG) and Back Surgery - The department implemented prior authorization reviews for elective coronary artery bypass graft (CABG) and elective back surgery procedures effective with inpatient admission dates beginning April 1, 2014. In FY15, the first full year of review activity, eQHealth conducted a total of 1,809 prior authorization reviews (137 CABG, 1,672 Back Surgery) and 184 reviews were referred for physician review of which only 6 requests were denied. So far there has been no evidence of over utilization for either clinical service. Prior authorization requests for elective back surgeries have been due to clinical conditions in which the patient has intractable pain, neurologic sequelae, impairment of activities of daily living

or an underlying congenital disorder. In each case, less invasive measures had failed to provide significant symptom improvement. As a result, this review type has failed to yield the cost savings outlined in the SMART Act.

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 – provides 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 2015, a decline in review volume was reported compared to FY14. In FY15 a total of 6,431 LTAC reviews were conducted for 1,739 LTAC hospitalizations. Medical/Surgical reviews comprised 85.4% of the review volume while 14.6% of the review volume was attributed to psych admissions. LTAC hospitals' certified days totaled 48,220 with 275 days denied. For FY15, the Average Length of Stay (ALOS) among all LTAC providers was 36 days which is up from 29 days for the previous fiscal year.

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.

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.

During Fiscal Year 2015, the OIG successfully implemented legislative and enforcement initiatives that resulted in $197 million dollars in cost savings, avoidance, and recoupment for the taxpayers of Illinois. See our annual reports at http://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx .

XIV. APPENDICES

Appendix A – Major Eligibility Groups Receiving Comprehensive Benefits

For more information about the programs described below or how to apply for them go to http://www.illinois.gov/hfs/Pages/default.aspx

All Kids Assist covers children 18 years of age and younger in families with income up to 147 percent of the FPL ($2,971 per month for a family of four). Children covered under All Kids Assist have no copayments or premiums.

All Kids Share covers children in families with income over 142 percent and at or below 157 percent of the FPL (between $2,972 and $3,173 a month for a family of four). Children in All Kids Share have a $2.00 generic prescriptions or $3.90 copayment or less for each medical service and brand name prescriptions 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 $3,174 and $4,224 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 generic prescription or $5 copayment for each medical service or brand name 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 318 percent of the FPL (between $4,225 and $6,426 for a family of four). 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 for generic and $7 for brand name drugs and hospital inpatient is $100 per admission.

DCFS healthcare coverage includes children in the custody of the Department of Children and Family Services (DCFS) as well as children placed in subsidized guardianship and adoption assistance arrangements. More information on DCFS programs may be found at: www.state.il.us/dcfs/index.shtml. No co-payments or premiums are charged for these children.

Moms and Babies covers pregnant women and their babies up to one year of age in families with income at or below 213 percent of the FPL (at or below $4,304 a month for

a family of four). Babies under one year of age are eligible at any income level if Medicaid covered their mother at the time of the child's birth. Moms and Babies enrollees have no copayments or premiums.

FamilyCare Assist covers parents and caretaker relatives raising dependent children. To be eligible, adults must have family income at or below 138 percent of the FPL ($2,789 per month for a family of four) for adults. Under FamilyCare Assist, adults have copayments of $2 per generic prescription, $3.90 per medical service or brand name prescription, and $3.90 per day for inpatient hospitalization.

ACA Adults covers adults' age 19-64 who are not parents raising children and who have income up to 138 percent of the FPL (monthly income up to $1,354 for an individual or $1,832 for a couple). January 2014 was the first possible month of coverage for these individuals. Clients have copayments of $2 per generic prescription, $3.90 per medical service or brand name prescription, and $3.90 per day for inpatient hospitalization.

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 for one person and $3,000 for a couple. Clients have copayments of $2 per generic prescription, $3.90 per medical service or brand name prescription, and $3.90 per day for inpatient hospitalization.

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. Clients have copayments of $2 per generic prescription, $3.90 per medical service or brand name prescription, and $3.90 per day for inpatient hospitalization.

Health Benefits for Persons with Breast or Cervical Cancer covers uninsured individuals who have been screened and found to need treatment for breast or cervical cancer as confirmed by the Department of Public Health. There is no income limit for the group. Clients have no copayments.

Health Benefits for Asylum Applicants and Torture Victims covers individuals who have an application for asylum pending with the U.S. Citizenship and Immigration Services or receive services from a federally funded torture treatment center. Coverage is limited to 24 months but can be extended up to 36 months if an asylum appeal is still pending. Clients have copayments of $2 per generic prescription, $3.90 per medical service or brand name prescription, and $3.90 per day for inpatient hospitalization.

Pay-In Spenddown enables individuals who meet the nonfinancial requirements of AABD medical, to enroll and pay the amount of their financial spenddown obligation (income or resources) to the Department, rather than having to submit bills and receipts

for medical expenses on a monthly basis to a caseworker. Copayments are the same as AABD.

Veterans Care covers 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 or under the Public Aid Code. Income limits vary by county and follow a gross means test set at the federal level. In Illinois, the upper income limits vary from about $3,200 a month in counties with the lowest per capita income to about $4,200 a month in counties with the highest per capita income. Monthly premiums are set at either $40 or $70 depending on income but most enrollees pay $40 per month. Veterans Care does not cover long term care services or non-emergency transportation. Veterans pay $15 per office visit, $6 per generic prescription, $14 per brand name prescription, $50 per emergency department visit, ten percent of the Department's rate for out-patient hospital care and $150 per inpatient admission. [HFS has been notified by the federal government that the Veterans Care Program does not meet the Minimum Essential Coverage requirements of the ACA. New applications, therefore, are no longer being accepted.]

Appendix B
Home and Community Based-Services Waivers
FFY2013 Capacity, Operating Agency, Waiver Begin/End Dates, Target Populations, Base Services and Waiver
Changes Since Last Renewal

Medically Fragile/Technology Dependent Children
Operating Agency: Division of Specialized Care for Children
Target Population: Medically Fragile, Technology Dependent children under age 21

Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date: 07/01/85 **Renewal:** 09/01/12-08/30/17 **SFY 15 Cap** 825 **# Served** 753 **Expenditures** $1,972,101	• Respite care • Environmental modifications • Specialized medical equipment and supplies, • Medically supervised day care, • Placement maintenance counseling, • Nurse and family training	None	

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 *(current waiver extended pending approval of renewal)* **SFY 15 Cap** 295 **# Served** 280 **Expenditures** $22,344,423	• 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 *(current waiver extended pending approval of renewal)* **SFY 15 Cap:** 1,440 **# Served** 1,395 **Expenditures** $17,836,705	• 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** 10/01/13-09/30/18 **SFY 15 Cap** 1537 **# Served** 1018 **Expenditures** $10,861,505	• 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 **SFY 15 Cap** 20,840 **# Served** 20,346 **Expenditures** $701,910,127	• 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 **SFY 15 Cap** 4,905 **# Served** 3,058 **Expenditures** $51,078,885	• 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 *(current waiver extended pending approval of renewal)* **SFY 15 Cap** 37,728 **# Served** 16,140 **Expenditures** $225,482,610	• 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 *(current waiver extended pending approval of renewal)* **SFY15 Cap** 57,000 **# Served** 46,816 **Expenditures** $368,447,987	• 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

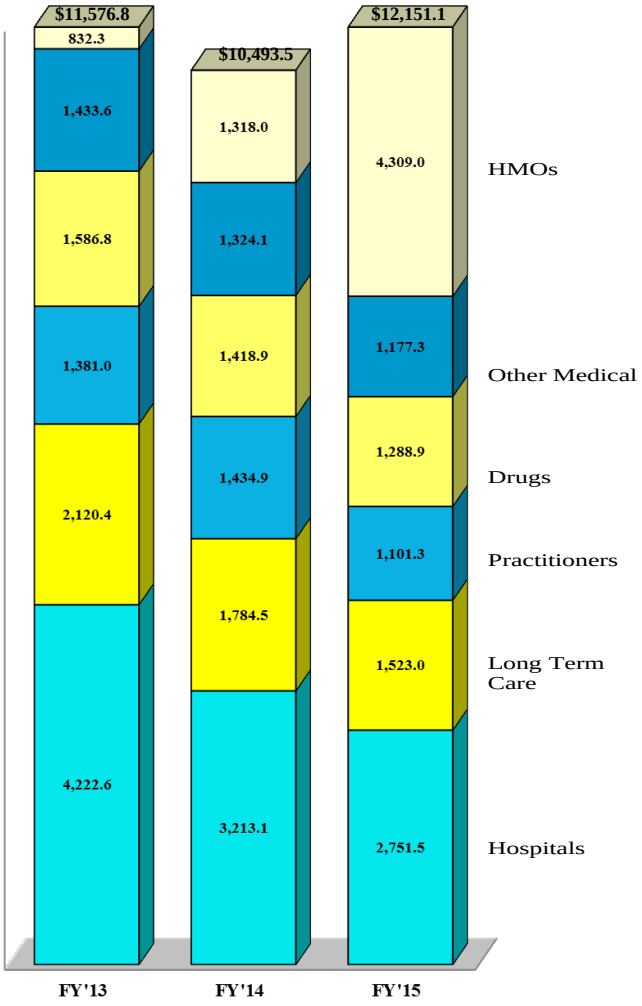
Begin/End Date	Base Services	Services added at Renewal	Modifications at Renewal or Waiver Amendments
Begin Date 07/01/99 **Renewal** 07/01/12-06/30/17 **FFY 15 Cap** 12,600 **Served** 10,229 **Expenditures** $ 129,807,055.10	• Nursing • Personal care • Medication oversight and assistance with self-administration • 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

APPENDIX C

Graph I
Healthcare and Family Services Spending by Major Spending Lines
Fiscal Year 2013-Fiscal Year 2015
Dollars in Millions

**Exclusions noted below*

Fiscal Year	Events That Affected Spending
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 Medicare premium amounts paid via offsets to FFP draws. Includes pay-down of unpaid bills accumulated during FY'12.
2014	Affordable Care Act (ACA) eligibility begins. Transition from fee-for-service to managed care leads to reductions in traditional provider line spending, as those expenditures transition to HMOs. Other Medical includes Medicare premium amounts paid via offsets to FFP draws.
2015	Implementation of PA 98-651 (SB 741). First full fiscal year of ACA enrollment. Reimbursement rates for many provider types were reduced by an average of 16.75% for May and June dates of service to achieve the equivalent value of a 2.25% 12-month reduction in total GRF appropriations to the Medical Assistance program. Hospitals increased their provider assessment in lieu of that reimbursement rate reduction. Family Health Plans within HMOs began mandatory enrollment in eligible counties in July 2014. Other Medical includes Medicare premium amounts paid via offsets to FFP draws. Affordable Care Act (ACA) eligibility begins. Transition from fee-for-service to managed care leads to reductions in traditional provider line spending, as those expenditures transition to HMOs. Other Medical includes Medicare premium amounts paid via offsets to FFP draws.

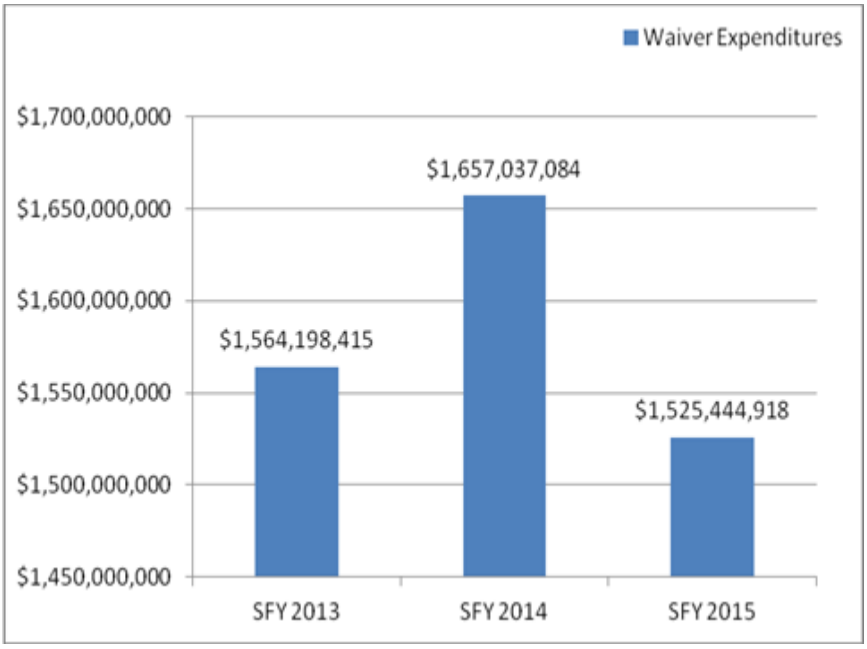


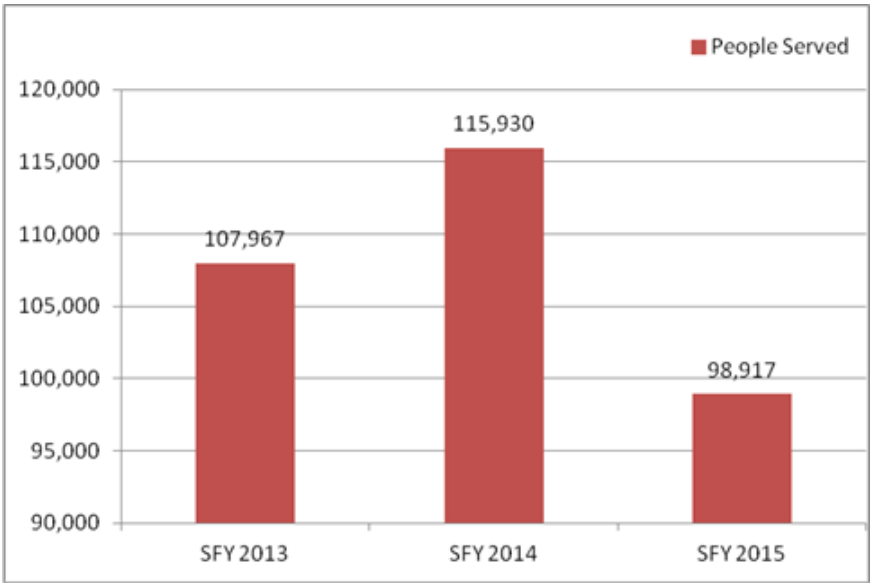
Notes:
Not included in total spending are expenditures from the (Cook) County Provider Trust, University of Illinois Hospital Services, Non-entitlements, Hospital Provider Fund (relating to the assessment), Trauma Center, Special Education Medicaid Matching, Money Follows the Person Budget Transfer, Electronic Health Record Incentive, Medicaid Buy-In, Medical Special Purposes Trust, Medical Interagency Program, and Juvenile Rehabilitation Services Funds.

Numbers may not appear to add due to rounding.

Graph Prepared By: Division of Finance
Data Source: Division of Finance, Comptroller Spending Report FY'15.

Appendix D
Medicaid Waiver Persons
and Expenditures
Waiver Years 2013 - 2015





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. SFY 2015 figures are preliminary and are expected to increase due to waiver expenditure data reported up to 18 months after expenditures are incurred.

Appendix E
Licensed/Medicaid Certified
Long Term Care Beds
Fiscal Year 2015 Actual

Level of Care	Medicaid Certified Beds [1]	Licensed Beds [2]
Skilled Care	69,441	79,064
Intermediate Care	14,357	16,053
Intermediate Care for the Mentally Retarded (ICF/MR)	4,854	4,854
Skilled Pediatric Care	932	932
Total	89,584	100,903

[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 Long Term Care Data Source: Bureau of Long Term Care and Department of Public Health

Appendix F
Long Term Care Total Charges and Liability on Claims Received
Fiscal Year 2013 - Fiscal Year 2015

	Long Term Care - Total			
	FY'13	FY'14	FY'15	Percent Change FY'13 to FY'15
Total Charges[1] ($ Millions)	$2,370.85	$2,254.53	$2,141.63	-4.92%
Total HFS Liability[1] ($ Millions)	$1,838.12	$1,740.66	$1,627.29	-6.37%
Total Patient Days ($ Millions)	19.14	17.93	15.83	-11.71%
Weighted Average Rate[2] Per Diem	$95.96	$96.94	$102.80	6.05%
Average Payment (Charge) Per Diem	$123.79	$125.62	$135.29	7.69%

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

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

Appendix G

Medical Assistance Program
Expenditures Against Appropriations
Fiscal Year 2013 -Fiscal Year 2015
Dollars in Thousands

	FY'13 Expenditures	FY'14 Expenditures	Percent	FY'15 Expenditures	Percent
Total [1,2]	**$11,576,777.4**	**$10,493,490.9**	**100.0%**	**$12,151,126.2**	**100.0%**
Hospitals	**4,222,599.6**	**3,213,119.4**	**30.6%**	**2,751,533.0**	**22.6%**
Long Term Care [3]	**2,120,445.8**	**1,784,454.3**	**17.0%**	**1,523,007.4**	**12.5%**
Practitioners	**1,381,022.2**	**1,434,926.3**	**13.7%**	**1,101,345.1**	**9.1%**
Physicians	1,101,322.5	1,131,432.0	10.8%	852,287.1	7.0%
Dentists	233,014.0	250,903.6	2.4%	209,875.8	1.7%
Optometrists	42,239.6	48,220.9	0.5%	35,593.0	0.3%
Podiatrists	3,909.9	3,966.8	0.0%	3,303.0	0.0%
Chiropractors	536.2	403.0	0.0%	286.2	0.0%
Drug	**1,586,813.6**	**1,418,893.4**	**13.5%**	**1,288,947.4**	**10.6%**
Other Medical	**1,428,645.7**	**1,323,580.9**	**12.6%**	**1,177,318.6**	**9.7%**
Laboratories	77,520.7	67,468.5	0.6%	54,881.0	0.5%
Transportation	83,255.0	79,834.3	0.8%	66,045.7	0.5%
SMIB/HIB/Expansion [4]	380,212.9	399,248.3	3.8%	405,292.2	3.3%
Home Health Care/DSCC	163,604.9	128,439.1	1.2%	127,442.8	1.0%
Appliances	94,308.1	80,484.9	0.8%	54,616.6	0.4%
Other Related [5]	164,042.5	146,130.4	1.4%	170,811.6	1.4%
Community Health Centers	290,847.8	263,999.0	2.5%	225,953.4	1.9%
Hospice Care	114,932.9	88,617.4	0.8%	72,275.3	0.6%
Children's Mental Health Initiative/SIU ACR	59,920.9	69,359.0	0.7%	0.0	0.0%
HMOs	**832,343.3**	**1,318,014.3**	**12.6%**	**4,308,974.7**	**35.5%**
Children's Health Rebate	**4,907.2**	**502.3**	**0.0%**	**0.0**	**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, Special Education Medicaid Matching, Money Follows the Person Budget Transfer, Electronic Health Record Incentive, Medicaid Buy-In, Medical Special Purposes Trust, Medical Interagency Program, 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 services, 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'15.

Appendix H
Medical Assistance
Mandatory/Optional Services FY 2015

FEDERALLY REQUIRED MEDICAL ASSISTANCE SERVICES

Certified pediatric and family nurse practitioner services	Laboratory and X-ray services
Emergency services	Medical/surgical services by a dentist
Emergency service for non-citizens	Nurse midwife services
EPSDT: Early and Periodic Screening, Diagnostic and Treatment Services for individuals under age 21	Nursing facility services (age 21 and over)
Family planning services and supplies	Physician medical and surgical services
Federally qualified health center services	Outpatient hospital services
Freestanding birth center services	Rural health clinic services
Home health services	Tobacco cessation counseling for pregnant women
Inpatient hospital services	Transportation to covered medical services

OPTIONAL SERVICES PROVIDED IN FY 2015

Audiology services	Occupational therapy services
Case management services	Optometric services
Certified Registered Nurse Anesthetist	PACE services
Chiropractic services	Physical therapy services
Clinic services (Medicaid Option/Community Mental Health)	Podiatric services
Clinical Nurse Specialist	Prescribed drugs
Dental services, including dentures	Preventive services
Diagnostic services	Prosthetic devices
Durable medical equipment and supplies	Rehabilitative services (Medicaid Rehab Option)
Eyeglasses	Services provided through a managed care health plan
Home and community-based services through federal waivers – For additional information refer to Appendix B of this report	Special TB services
Hospice services	Speech, hearing and language therapy services
Inpatient psychiatric services (IMD) for individuals 21 and under, including State-operated facilities	Transplant services
Intermediate care facility services for individuals with intellectual disabilities, including State-operated facilities	
Nursing facility services for individuals under 21 years of age	

Appendix I
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, 2015, the Health Benefits/All Kids and the Drug Prior Approval Hotlines received and handled over 618,000 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 over 225,000 calls. The hotline staff also process prior approval/refill too soon/4 prescription policy received via facsimile. In this same time period, over 200,000 requests were entered for review by pharmacy staff.

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 LTC services as a result of *Public Act 98-0104*.