ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

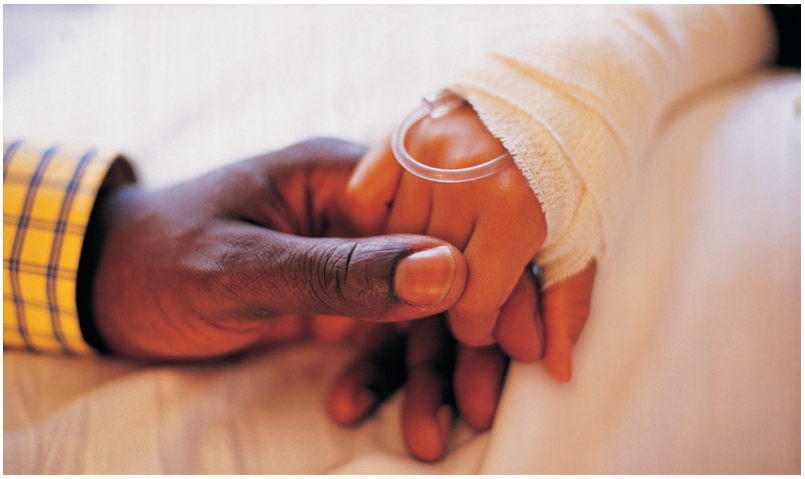
Bruce Rauner, Governor
Felicia F. Norwood, HFS Director

FY 2016

ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

March 31, 2017



A LETTER FROM THE DIRECTOR

Bruce Rauner, Governor

Felicia F. Norwood, Director

To the Honorable Bruce Rauner, Governor
And Members of the General Assembly:

On behalf of the Department of Healthcare and Family Services (Department), I present the Fiscal Year 2016 Annual Report of the Department's medical assistance programs. The Department provides health care coverage to approximately 3.2 million Illinoisans who represent the State's most vulnerable populations -- children, seniors, individuals with disabilities, and adults such as the expanded population under the Affordable Care Act. The medical assistance programs are most commonly known as Medicaid, CHIP, and All Kids.

The Department provides a wide variety of health care services through its programs in partnership with the federal government, managed care companies, and thousands of medical providers. The Department is committed to empowering Illinoisans to make sound decisions and improving their health by providing accessible, quality-driven health care coverage at sustainable costs. The Department also seeks to enable seniors and people with disabilities to live in their homes or community-based settings.

This report provides details on specific initiatives, participant numbers, and provider reimbursement for Fiscal Year 2016 and, in some instances, the two previous years for purpose of comparisons and statutory requirements. I hope you find this report informative and useful as we work together to transform the Department's medical assistance programs.

Sincerely,

Felicia F. Norwood
Director

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CHAPTER 1

OVERVIEW

ABOUT HFS

The Department of Healthcare and Family Services (Department, HFS, or Agency) administers the medical assistance programs most commonly known as Medicaid, CHIP, and All Kids. These programs are jointly financed by State and federal government funds and provide critical health care coverage to Illinois' most vulnerable populations.

MISSION

The Department is committed to ensuring quality health care coverage at sustainable costs, empowering people to make sound decisions about their wellbeing, and maintaining the highest standards of program integrity on behalf of Illinoisans.

COVERAGE

The Department provides medical coverage to approximately one quarter of the State's population. Enrollment as of June 30 for the last three completed fiscal years (FY) (Illinois' FY is from July 1 to June 30) is as follows:

Enrollees/Benefits	FY 2014	FY 2015	FY 2016
Children	1,572,082	1,516,769	1,490,290
Adults with Disabilities	254,091	252,313	249,241
Other Adults	657,578	631,126	607,827
Seniors	190,575	195,102	200,692
ACA Newly Eligible Adults	468,523	635,972	637,056
All Comprehensive	3,142,849	3,231,282	3,185,106
All Partial Benefits	67,651	16,400	16,486
Grand Total All Enrollees	**3,210,500**	**3,247,722**	**3,202,330**

HEALTH CARE PROGRAMS

The following are the health care programs provided by HFS. For more information about these programs and how to apply, visit: www.illinois.gov/hfs/MedicalClients/Pages/medicalprograms.aspx.

All Kids Assist

Eligibility - Children up to 19 with family income at or below 147% of the Federal Poverty Limit (FPL) ($3,014 per month for family of four (4)). **Presumptive Eligibility** - Yes **Benefit** - Comprehensive **Cost Sharing** - No

All Kids Share

Eligibility - Children up to 19 with family income above 147% and at or below 157% FPL (between $3,015 and $3,219 a month for a family of four (4)). **Presumptive Eligibility** - Yes **Benefit** - Comprehensive **Cost Sharing** - Yes

All Kids Premium Level 1

Eligibility - Children up to 19 with family income above 157% and at or below 209% FPL (between $3,220 and $4,285 a month for a family of four (4)). **Presumptive Eligibility** - Yes **Benefit** - Comprehensive **Cost Sharing** - Yes

All Kids Premium Level 2

Eligibility - Children up to 19 with family income above 209% and at or below 318% FPL (between $4,286 and $6,519 per month for a family of four (4)). **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - Yes

Department of Children and Family Services (DCFS)

Eligibility - Children in DCFS custody and those placed in subsidized guardianship and adoption assistance arrangements. No income or resource limitations. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - No

Former Foster Care

Eligibility - Former DCFS youth in care age 19-26 who were enrolled in Medicaid when aged out of foster care. No income or resource limitations. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - Yes

Moms and Babies

Eligibility - Pregnant women and their babies up to age one (1) with a family income at or below 213% FPL (at or below $4,367 a month for a family of three (3) plus the unborn baby). Babies under one (1) are eligible at any income level if Medicaid covered their mother at the time of birth. **Presumptive Eligibility** - Yes **Benefit** - Comprehensive **Cost Sharing** - No

FamilyCare Assist

Eligibility - Parents and caretaker relatives raising dependent minor children with an income at or below 138% FPL ($2,829 per month for a family of four (4)) for adults. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - Yes

ACA Adults

Eligibility - Adults age 19-64 without minor children in the home who do not receive Medicare and have income up to 138% FPL (monthly income up to $1,387 for an individual or $1,868 for a couple). **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - Yes

Aid to Aged Blind and Disabled (AABD/Seniors and Persons with Disability) Medical

Eligibility - Persons who are 65 and older, who are blind, or who are disabled, with monthly income up to 100% FPL ($1,005 for a single person and $1,353 for a couple) and no more than $2,000 of non-exempt resources for one person and $3,000 for a couple. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - Yes

1619A and 1619B

Eligibility - Individuals who are employed. 1619 (a) individuals have employment earnings low enough to receive some portion of a Supplemental Security Income (SSI) check. 1619 (b) individuals have higher earnings and receive no SSI income benefits. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - Yes

Health Benefits for Workers with Disabilities (HBWD)

Eligibility - Employed persons with disabilities with earnings up to 350% FPL ($3,518 per month for an individual, $4,737 per month for a couple) who buy into Medicaid by paying a small monthly premium. May have up to $25,000 in non-exempt resources. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - Yes

Health Benefits for Persons with Breast or Cervical Cancer

Eligibility - Individuals under 65 without insurance that covers cancer treatment and whose breast or cervical cancer diagnosis has been confirmed by the Department of Public Health. There is no income limit. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - No

Health Benefits for Asylum Applicants and Torture Victims

Eligibility - Individuals with pending applications for asylum with the U.S. Citizenship and Immigration Services or who receive services from a federally-funded torture treatment center. Same income and resource standards as AABD medical. **Presumptive Eligibility** - No **Benefit** - Comprehensive for limited time **Cost Sharing** - Yes

Veterans Care (New enrollment closed - effective March 2016)

Eligibility - Uninsured veterans age 19-64, who were not dishonorably discharged from the military, served 180 days in the military after initial training, are income eligible, and are not eligible for health care from the U.S. Department of Veterans Affairs or medical assistance under the Public Aid Code. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - Yes

Emergency Medical for Non-Citizens

Eligibility - Persons who are not U.S. citizens or do not have a legal status that qualifies them for Medicaid under federal law and who meet all other nonfinancial and financial criteria for FamilyCare Assist, AABD, or the ACA Adult group. **Presumptive Eligibility** - No **Benefit** - Partial **Cost Sharing** - No

Medicare Saving Program (MSP)

Eligibility - Individuals eligible for Medicare Part A with income less than 135% FPL. There are three (3) programs. Income limits vary per program. Resource limits for all three (3) programs are $7,280 for a single person and $10,930 for a couple. **Presumptive Eligibility** - No **Benefit** - Coverage of Medicare cost sharing expenses **Cost Sharing** - Not Applicable

State Hemophilia Program

Eligibility - Any Illinois resident with health insurance and a bleeding or clotting disorder who is not eligible under another group. **Presumptive Eligibility** - No **Benefit** - Partial **Cost Sharing** - Yes

State Chronic Renal Disease Program

Eligibility - Illinois residents with health insurance who meet citizenship requirements and are not eligible for coverage under Medicaid or Medicare who require lifesaving care and treatment for chronic renal disease but are unable to cover the out-of-pocket costs. **Presumptive Eligibility** - No **Benefit** - Partial **Cost Sharing** - Yes

State Sexual Assault Survivors Emergency Treatment Program

Eligibility - Survivors of sexual assault who are not enrolled in another group. **Presumptive Eligibility** - No **Benefit** - Partial **Cost Sharing** - No

*Income and resource limits are for federal fiscal year 2017 (10/01/16 thru 09/30/17)

Client Hotline Numbers

As of June 30, 2016, the Health Benefits/All Kids, Drug Prior Approval/Refill Too Soon, and Provider Hotlines received and handled over 542,000 calls from clients and providers. The Health Benefits/All Kids hotline responded to over 268,700 calls, the Drug Prior Approval/Refill Too Soon Hotline answered over 189,500 calls, and the Provider Hotline answered nearly 84,000 calls.

All Kids	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, it connects to the Illinois Health Benefits and the All Kids Hotline.)	1-877-543-7669

In FY 2015, about 20 cents of every dollar spent on Medicaid came from general State tax dollars. In FY 2016, that number was down to under 16 cents of every dollar.

PROGRAM COSTS

During FY 2016 (July 1, 2015 through June 30, 2016), the State spent approximately $17.8 billion (all funds), of which $12.5 billion was from the General Revenue Fund (GRF) or GRF-like funds on enrollee health benefits and related services. A small portion of this spending occurs in budgets of State and local partners outside of HFS. (See Table II in appendix for HFS FY 2016 spending by appropriation line).

Medical Programs Spending

FY 2014 - 2016
Dollars in Millions

2014 - ACA eligibility begins. Transition from fee-for-service (FFS) to managed care leads to reductions in traditional provider line spending as those expenditures transition to Managed Care Organizations (MCOs).

"Other Medical" includes Medicare premium amounts paid via offsets to Federal Financial Participation (FFP) draws.

2015 - Implementation of **Public Act 98-651**. 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.

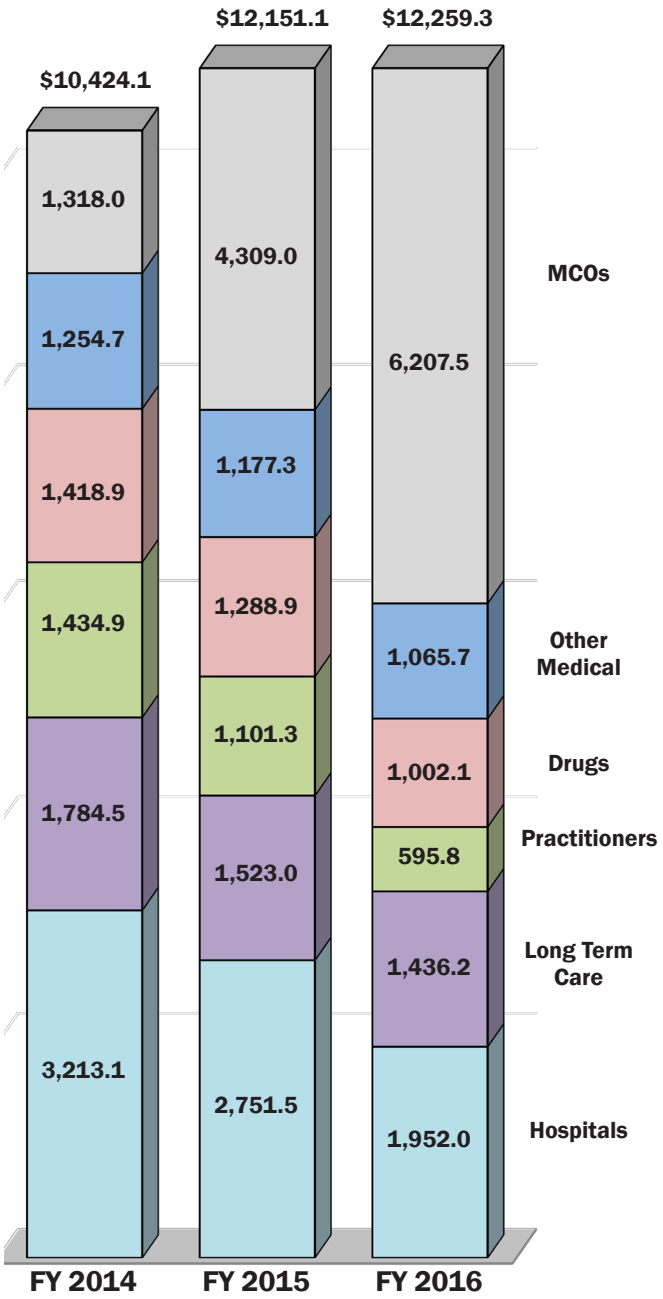
Mandatory MCO enrollment for eligible groups in eligible counties began in July 2014.

"Other Medical" includes Medicare premium amounts paid via offsets to FFP draws.

2016 - FY 2016 is the first fiscal year with the completed conversion to mandatory managed care. To provide improved care while saving costs, the Governor's budget proposal led to the phase out of CCEs and ACEs. Within managed care programs, HFS is absorbing other agencies' FFS costs that are now included in the MCO capitated rates.

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 2016.

PARTNERS

Through its role as the designated single state Medicaid agency, the Department works with several other agencies that manage important portions of the program including: the Department of Human Services; the Department of Public Health; the Department of Children and Family Services; the Department on Aging; the University of Illinois at Chicago Division of Specialized Care for Children; the University of Illinois Office of Medicaid Innovation; the Cook County Bureau of Health and Hospital Services; certain other county-based local health providers; and hundreds of local school districts.

The Department also partners with MCOs and thousands of health care providers to deliver health care to over 3 million Illinoisans.

ENABLING LEGISLATION

The Department administers its medical assistance programs under the Illinois Public Aid Code (305 ILCS 5/), the Children's Health Insurance Program Act (215 ILCS 106/), the Covering ALL KIDS Health Insurance Act (215 ILCS 170/), and Titles XIX and XXI of the federal Social Security Act.

CHAPTER 2

TRANSFORMING MEDICAID

TRANSFORMING MEDICAID

The Department of Healthcare and Family Services (Department, HFS, or Agency) is the largest insurer in Illinois. The Department is accountable to Illinoisans and committed to ensuring quality, accessible health care coverage at sustainable costs. To continually advance the Department's mission, the Department is embarking on a series of transformation initiatives of the State's entire HHS system to achieve the critical objective of paying for quality, value, and outcomes. (**https://www.illinois.gov/sites/hhstransformation/Pages/default.aspx**).

The initial focus of the transformation effort is on behavioral health (mental health and substance use) and specifically, the integration of behavioral and physical health care service delivery. (See Illinois' Behavioral Health Transformation 1115 waiver at **https://www.illinois.gov/hfs/info/1115Waiver/Pages/default.aspx**.) Behavioral health was chosen due to the urgency of the issue (opioid epidemic, increased violent crime, and needed improvement in maternal and child health) as well as the potential financial and human impact. Medicaid members with behavioral health needs represent 25% of Illinois Medicaid members but account for 56% of all Medicaid spending. (See chart on page 6 at: **https://www.illinois.gov/hfs/SiteCollectionDocuments/1115%20Waiver%20for%20CMS%20Submission_final.pdf**.)

For more information, visit the transformation webpage at **https://www.illinois.gov/sites/hhstransformation/Pages/default.aspx**.

Guiding Principles for Medicaid Transformation

Right Kind of Care
Receive the right care, at the right time, at the right cost

Holistic Care
Integrate the physical and mental health needs of beneficiaries

Evidence-Based Care
Evidence-based care delivers the best quality at the lowest cost

Outcome-Based Care
Pay for what works to improve and maintain health and stop paying for what doesn't work

Preventive Care
Transform health care from a system that reacts after someone gets sick to a system that focuses on prevention and keeping beneficiaries healthy

Chronic Disease Management
Prevent chronic disease whenever possible and coordinate care to improve quality of life and reduce chronic care costs

Community-Based Settings
Enable seniors and people with disabilities to live in their homes or community-based settings instead of a higher-cost setting such as a nursing home

"Transformation puts a strong new focus on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data-driven decisions; and moves individuals from institutions to community care, to keep them more closely connected with their families and communities."

Governor Bruce Rauner, 2016 State of the State

Technology Transformation

Technology initiatives are an essential part of HFS' Medicaid transformation agenda. The following systems changes will allow the Department to achieve necessary programmatic and financial objectives:

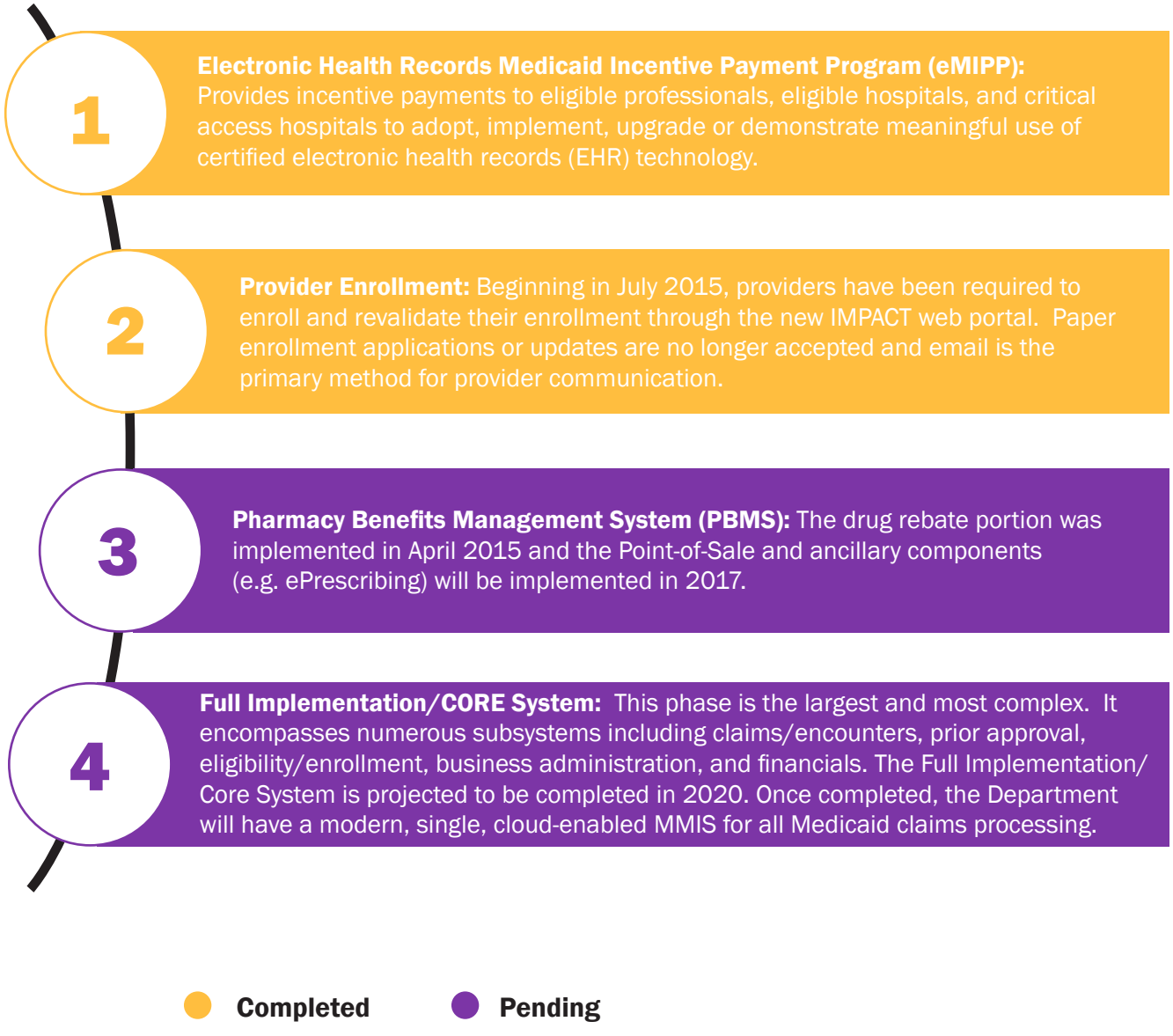
The **Integrated Eligibility System (IES)** determines eligibility for all medical programs; Supplemental Nutrition Assistance Program (SNAP), formerly known as "food stamps"; and cash assistance, primarily for Temporary Assistance for Needy Families (TANF). IES, currently in phase 2, replaces the 30 plus-year old COBOL mainframe application that was built before there was a functional internet or wide use of relational databases. HFS is implementing IES in collaboration with the Department of Human Services (DHS) and the Department of Innovation and Technology (DoIT). The cost of development and installation of the IES is currently being largely defrayed by an enhanced 90% match rate from the federal government. See **https://abe.illinois.gov/abe/access/** for more information.

The **Illinois Medicaid Program Advanced Cloud Technology (IMPACT)** initiative is a multi-agency effort that modernizes the Department's 30 year-old Medicaid Management Information System (MMIS) which was built to support a fee-for-service Medicaid program. The MMIS supports claims processing for the HFS medical assistance programs.
The MMIS environment includes:

- Database Subsystems (e.g., Provider, Recipient, Reference, and Prior Approval)
- Hospital, Pharmacy, and NIPS Claims Processing Subsystems
- Management and Reporting System (MARS)
- Enterprise Data Warehouse
- Pharmacy Point-of-Sale System
- Web-based Applications Provided in the Medical Electronic Data Interchange (MEDI) system

Throughout the years, HFS made many enhancements and modifications to the MMIS; however, it is an older legacy system that is becoming increasingly more difficult to maintain and modify. Rather than develop a new system, Illinois is obtaining a federally-certified MMIS through an intergovernmental agreement with the Michigan Department of Community Health (MDCH), which is being enhanced to fulfill HFS' business needs. By implementing an enhanced MDCH MMIS and not building a new system, up-front development costs are decreased and the time required for implementation is reduced by approximately two years.

IMPACT's Four (4) Phases:



CHAPTER 3

CARE COORDINATION

CARE COORDINATION

Overview

Care Coordination Mandate: **Public Act 96-1501** (2011) mandated that at least 50% of clients of the Department of Healthcare and Family Services (Department, Agency, or HFS) be in some form of risk-based care coordination by January 1, 2015. Managed care offers a way to deliver better health care services with the long term promise of reduced costs. This section provides a brief overview of the Department's care coordination program. For more information, visit the HFS website at **https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/default.aspx**.

Transformation

Effective managed care expansion has been central to the Department's planning and essential to the transformation of the Illinois Medicaid program.

MCO Migration: In Fiscal Year (FY) 2016, HFS continued to migrate its poplulation into managed care culminating in over 60% of beneficiaries enrolled in risk-based managed care organizations (MCO). It is expected that within the next two years, over two-thirds of beneficiaries will be transitioned into MCOs. In FY 2017, the Department implemented the Managed Long Term Services and Supports (MLTSS) program, a new mandatory managed care program for dual eligibles (individuals enrolled in both the Medicare and Medicaid program) receiving long term services and supports who choose not to enroll in the Medicare-Medicaid Alignment Initiative (MMAI).

Reduction in Non-Risk Bearing Managed Care Entities: As of the date of this report, March 31, 2017, the number of managed care entities has been reduced from 30 to 12 mostly due to the alignment of accountable care entities (ACE) and care coordination entities (CCE) with MCOs.

MCO RFP: On February 27, 2017, the Department posted a Request for Proposals (RFP) seeking services from qualified, experienced, and financially sound MCOs to enter into risk-based contracts. The Department intends for these contractors to provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system and seeks to reduce the number of MCOs to between four (4) and seven (7).

Provider Complaint Portal: The continued expansion of managed care has meant that providers must learn to operate in a new environment and the MCOs and providers must learn to work together to resolve issues. As could be expected, this has resulted in some issues between the provider community and the MCOs regarding payment and operations. To help ease this transition, the Department, in collaboration with the University of Illinois' Office of Medicaid Innovation, began designing an MCO Provider Complaint Portal in 2016 which was rolled out in February 2017. See **https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/ManagedCareComplaints.aspx**. The secure electronic web-based portal is to be utilized after the provider has tried to resolve the issue with the MCO. A major goal of the new MCO provider complaint portal is to address and answer MCO-related questions promptly and to ensure fair resolution of

disputes between MCOs and providers. HFS will collect and publicly report the volume of complaints received and resolved by provider type, MCO, and other categories and will use information obtained from the portal to further enhance the managed care program.

Illinois Medicaid Plan Report Card: In FY 2016, HFS created a consumer quality comparison tool called the Illinois Medicaid Plan Report Card to help individuals pick the MCO that is best for them. This report card is for individuals in the Family Health Plan/Affordable Care Act (FHP/ACA) program and Integrated Care Program (ICP). The report card shows how each MCO does in providing care and services to their members for specific measures in key performance areas. The report card is posted on the HFS home page, under Health Plan Comparison Tool at **https://www.illinois.gov/hfs/pages/default.aspx**.

MCO Operations Metrics: In FY 2016, the Department began developing additional reporting requirements for the MCOs to report MCO operations metrics to HFS on a quarterly basis for individuals in the FHP/ACA and ICP programs. In December 2016, the Department began publishing the operations metrics on the HFS website and updates the reports as the process is further developed with the MCOs. Some of the operations metrics include timeliness and accuracy of claims payments, prior authorizations, grievance and appeals, utilization statistics, provider disputes, and provider credentialing. See "Care Coordination Operation Metrics" at **https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/default.aspx**.

Non-Risk Bearing Program

Primary Care Case Management (PCCM) Program: The PCCM program is called Illinois Health Connect (IHC). IHC provides care coordination Statewide for individuals in counties where there is no mandatory participation in MCOs and who were not eligible to participate in MCOs. In FY 2016, these persons were individuals with other insurance, individuals receiving supplemental security income, Department of Children and Family Services (DCFS) children, and children participating in the care coordination program operated by the Division of Specialized Care for Children (DSCC). Although IHC is not a Statewide health plan choice, it is the primary resource for these individuals to find providers for primary and preventive care. IHC links individuals to primary care providers (PCP) at assigned medical homes and assists in locating providers for services and making appointments as needed. As of June 30, 2016, almost 326,000 Medicaid clients in the non-mandatory counties were enrolled with a PCP in IHC. PCPs participating in IHC receive a monthly care management fee for each individual they accept as a patient. PCPs are eligible to receive annual bonus payments for each qualifying service under defined bonus measurements. The bonus program increases the quality and access to care by encouraging PCPs to provide primary and preventive services in accordance with the quality measurements and drives adoption of quality improvement initiatives. Visit the IHC website at **http://www.illinoishealthconnect.com/provider/quality-tools/panelrosters.aspx** for more information.

Accountable Care Entity (ACE) and Care Coordination Entity (CCE): During FY 2016, the managed care transformation included alignment of the MCOs with (1) CCEs for Seniors and Persons with Disabilities (SPD) and Children with Special Needs and (2) ACEs for children, their families, and adults under the ACA. Through the alignment with the MCOs, beneficiaries were transitioned from fee-for-service (FFS) to risk-based programs on expedited schedules. As a result, the number of HFS contracting entities for mandatory

managed care coordination was reduced from 30 to 14 by June 30, 2016. The ACE, SmartPlan Choice, had 43,728 enrollees as of June 30, 2016 but completed its alignment with an MCO on September 1, 2016. This final ACE alignment further reduced the number of HFS contracting entities to 13 as of September 1, 2016. Note as of the date of this report, March 31, 2017, the number of MCOs was reduced to 12 due to the discontinuation of participation by Health Alliance Medical Plan/Connect.

Risk Bearing Program

MCOs: Two types of risk bearing entities participate in the Department's managed care program: health maintenance organizations (HMOs) and managed care community networks (MCCN) (together MCOs or Health Plans). HMOs are licensed by the Department of Insurance (DOI) and are not provider owned. MCCNs (1) are owned, operated, or governed by providers of health care services within Illinois; (2) provide or arrange for primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department; and (3) are certified by the Department and not DOI. Except for financial solvency and licensing requirements, HMOs and MCCNs have the same contractual requirements.

Types of MCOs: There are four (4) MCO Programs: ICP, FHP/ACA, MMAI, and MLTSS (beginning in FY 2017). See towards the end of this chapter tables for a description of enrollees, enrollment, and service area for FY 2016.

Benefits Provided by MCOs: For clients who are not dual eligible, the Department's contracts require MCOs to offer the same comprehensive set of services that are available to the FFS population such as physician and specialist care, emergency care, laboratory and x-rays, mental health, pharmacy, dental, vision, and substance use services, case management, and long term services and supports (LTSS) (nursing facilities or in the home through Home and Community-Based Services (HCBS) waivers). Dual eligibles enrolled in MLTSS will receive some Medicaid-covered services from their MLTSS MCO, including long term care, waiver services, behavioral health services, non-emergency transportation, and care coordination and will receive their Medicare-covered services such as hospitalization, doctor visits, therapies, prescriptions, laboratory and x-rays, and medical supplies through Medicare FFS, Medicare Part D, or Medicare Advantage. Dual eligibles in MMAI MCOs receive 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.

MCO Reimbursement: MCOs are reimbursed through capitation rates. Capitation rates are a fixed amount of money, commonly known as per member per month (PMPM) payments, which the Department pays monthly to the MCOs to assume full responsibility or risk for providing the Department's clients with health care services.

Non-MMAI MCO Reimbursement: For enrollees who are not in the MMAI, the Department's actuary develops the MCO rates based on FFS claims experience, health plan claims experience, and enrollment data. For non FHP/ACA , rates differ based on the type of enrollee (SPD or MLTSS) and the care setting (community residents, nursing facility residents, enrollees in HCBS waivers, etc.). For FHP/ACA, rates are

based on age and sex. For all MCOs, there are adjustments for health care management, trend, and health plan administration. In addition to capitation rates, ICP and FHP/ACA contracts have pay for performance (P4P) measures to incentivize spending on care that produces healthy quality-of-life outcomes (such as managing chronic illnesses (including diabetes, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease (COPD)); monitoring emergency department visits and utilization; and ensuring members follow up with a provider within 30 days after receiving a mental health diagnosis and within fourteen days after an inpatient discharge). The ICP and FHP/ACA contracts also have payment withholds when the MCOs do not spend their capitation payments on care that produces quality outcomes. Lastly, each MCO contract has medical loss ratio (MLR) requirements. For example, for ICP, the MLR is 88%; meaning that 88% of the revenue from the contract must be spent on health care services to enrollees. For the remaining MCOs, the MLR is 85%.

MMAI MCO Reimbursement: MMAI demonstration contracts are three-party agreements between the Centers for Medicare and Medicaid Services (CMS), the Department, and each MCO. Both CMS and HFS contribute to the MMAI capitation payments. MMAI MCOs receive three monthly payments for each enrollee: (1) from CMS reflecting coverage of Medicare Parts A/B services, (2) from CMS reflecting coverage of Medicare Part D services, and (3) 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 CMS models based on an enrollee's age, geographic service area, and care setting (nursing facility, waiver, waiver plus, and community). The MLR is 85%.

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.

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

To ensure that MMAI enrollees receive high quality care and to incentivize MCO quality improvement, both Medicare and Medicaid also 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.

MCO Assessment of Need: MCOs must assess the care management and disease management needs of their clients within contractually described time periods and develop any necessary person centered care plans. The tools used vary per MCO and the medical assistance program in which the clients are enrolled but generally involve population and individual based tools that stratify a client by risk level: low, moderate, and high. There is outreach and intervention at each level -- the higher the risk, the higher the outreach and intervention.

MCO Program Information

ICP	Health Plans	June 2016 Enrollment
Enrollees: Seniors and Persons with Disabilities **Geographic Service Area:** Cook County, Collar Counties, Northwest Illinois Region, Central Illinois Region, and Metro East Region **Mandatory Enrollment:** As of December 1, 2016, in all regions but Central Illinois Region	Aetna Better Health Inc.	29,261
	Blue Cross/Blue Shield of Illinois	11,098
	Cigna HealthSpring of Illinois	5,825
	Community Care Alliance of Illinois	9,166
	CountyCare Health Plan	4,508
	Health Alliance Medical Plan	7,966
	Humana Health Plan	4,922
	IlliniCare Health Plan Inc.	27,539
	Meridian Health Plan Inc.	11,727
	Molina Healthcare of Illinois Inc,	5,957
	NextLevel Health (MCCN as of January 1, 2016)	4,019
	Total Health Plan Enrollment	**121,988**

FHP/ACA	Health Plans	June 2016 Enrollment
Enrollees: Children and their families and ACA adults **Geographic Service Area:** Cook County, Collar Counties, Northwest Illinois Region, Central Illinois Region, and Metro East Region **Mandatory Enrollment:** As of December 1, 2016, in all regions but Central Illinois Region	Aetna Better Health Inc.	167,061
	Blue Cross/Blue Shield of Illinois	284,897
	CountyCare Health Plan	149,994
	Family Health Network	240,726
	Harmony Health Plan of Illinois Inc.	167,169
	Health Alliance Connect Inc.	123,020
	IlliniCare Health Plan Inc.	170,440
	Meridian Health Plan Inc.	347,837
	Molina Healthcare of Illinois Inc.	190,432
	NextLevel Health (MCCN as of January 1, 2016)	22,388
	Total Health Plan Enrollment	**1,863,964**

MMAI	Health Plans	June 2016 Enrollment
Enrollees: Dual eligibles, individuals age 21 and over who are eligible for both Medicare and Medicaid services **Geographic Service Area:** Cook County, Collar Counties, and Central Illinois Region **Mandatory Enrollment:** No	Aetna Better Health Inc.	6,458
	Blue Cross/Blue Shield of Illinois	13,671
	Cigna HealthSpring of Illinois	6,487
	Humana Health Plan	6,597
	IlliniCare Health Plan Inc.	5,146
	Meridian Health Plan Inc.	5,731
	Molina Healthcare of Illinois Inc.	4,128
	Total Health Plan Enrollment	**48,218**

MCO Program	Health Plans	June 2016 Enrollment
ICP, FHP/ACA, MMAI	Aetna Better Health Inc.	202,780
ICP, FHP/ACA, MMAI	Blue Cross/Blue Shield of Illinois	309,666
ICP, MMAI	Cigna HealthSpring of Illinois	12,312
ICP	Community Care Alliance of Illinois	9,166
ICP, FHP/ACA	CountyCare Health Plan	154,502
FHP/ACA	Family Health Network	240,726
FHP/ACA	Harmony Health Plan of Illinois Inc.	167,169
ICP, FHP/ACA	Health Alliance Medical Plan/Connect	130,986
ICP, MMAI	Humana Health Plan	11,519
ICP, FHP/ACA, MMAI	IlliniCare Health Plan Inc.	203,125
ICP, FHP/ACA, MMAI	Meridian Health Plan Inc.	365,295
ICP, FHP/ACA, MMAI	Molina Healthcare of Illinois Inc.	200,517
ICP, FHP/ACA	NextLevel Health (MCCN as of January 1, 2016)	26,407
	Total MCO Enrollment	**2,034,170**

Quality Assurance

State Quality Assessment and Performance Improvement Strategy for Managed Care

As required by federal regulation and with a goal to accomplish HFS' mission of empowering individuals enrolled in MCOs to improve their health while containing costs and maintaining program integrity, HFS developed the MCO State Quality Strategy (Quality Strategy). The Quality Strategy establishes a framework for ongoing assessment and identification of potential opportunities for health care coordination and improvement and ensuring the delivery of the highest quality and most cost-effective services possible. The Quality Strategy was developed with input from provider groups, advocates, MCOs, and HFS staff and was reviewed by CMS. The quality strategy has five (5) goals identified in the box at the right.

External Quality Review Organization

Federal regulation (**42 CFR Part 438 Subpart E**) requires that specific review activities be performed on MCOs by an External Quality Review Organization (EQRO). HFS' EQRO conducts:

- An annual mandated review using CMS protocols to assess the completeness of the Quality Strategy
  - Quality Assurance Plan Compliance Review (e.g. readiness reviews for new plans prior to implementation and monitoring the quality of services and supports provided to HCBS participants)
  - Validation of Performance Measures
  - Validation of Performance Improvement Projects
  - Overall Evaluation of the Quality Strategy
  - Technical Assistance on Quality Assurance Monitoring to MCOs and HFS (at the direction of HFS)
- A separate annual Consumer Assessment of Health Care Providers and Systems (CAHPS) survey for both the Medicaid program and the Children's Health Insurance Program (CHIP) which includes questions on children with chronic conditions.

5 Goals of 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

Ensure integrated care delivery – 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 managed care programs.

Goal 5

Ensure efficient and effective administration of Illinois Medicaid managed care programs.

CHAPTER 4

LONG TERM SERVICES & SUPPORTS

LONG TERM SERVICES & SUPPORTS

This section provides an overview of the following components of the long term services & support program administered by the Department of Healthcare and Family Services (Department, Agency, or HFS): Institutional, 1915(c) Home and Community-Based Services Waivers, and other community programs. For more information visit the Department's website at **https://www.illinois.gov/hfs/MedicalProviders/ltss/Pages/default.aspx**.

Institutional

The Department is responsible for the Medicaid Long Term Care (LTC) program. The mission is to ensure that the LTC services are appropriate for and meet the needs of recipients, meet standards of quality, and are in compliance with federal and State regulations. This section gives basic information about the LTC program and provides a more detailed summary of nursing facilities (NF), which are overseen by both the Department and the Illinois Department of Public Health (IDPH).

There are three (3) basic types of institutional settings in the LTC program: NF, Specialized Mental Health Rehabilitation Facilities (SMHRFs)[1], and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs).

Number of Facilities & Number of Beneficiaries Served

Nursing Facilities (NF):

- 703 NFs
- Averaged just over 48,600 beneficiaries served in FY 2016

Specialized Mental Health Rehabilitation Facilities (SMHRFs)

- 24 SMHRFs
- Just under 4,000 beneficiaries served in FY 2016

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)

- 248 ICF/IIDs
- Just over 5,000 beneficiaries served in FY 2016

[1]SMHRFs are pending licensure by IDPH

Licensed & Medicaid Certified LTC Beds
Fiscal Year 2016 Actual

Level of Care	Medicaid Certified Beds[1]	Licensed Beds[2]
Skilled Care	70,104	79,582
Intermediate Care	13,622	15,366
Intermediate Care for Individuals with Intellectual Disabilities	4,661	4,661
Skilled Pediatric Care	932	932
Total	**89,319**	**100,541**

[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 Rate Development and Analysis

LTC Total Charges and Liability on Claims Received
Fiscal Year 2014 - 2016

Long Term Care - Total				
	FY 2014	FY 2015	FY 2016	% Change FY 2014 to FY 2016
Total Changes[1] ($ Millions)	$2,254.53	$2,141.63	$1, 956.60	-13.21%
Total HFS Liability[1] ($ Millions)	$1,740.66	$1,627.29	$1,478.25	-15.08%
Total Patient Days ($ Millions)	$17.93	$15.83	$14.15	-21.08%
Weighted Average Rate[2] Per-Diem	$96.94	$102.80	$104.47	7.77%
Average Payment (Charge) Per-Diem	$125.62	$135.29	$138.28	10.07%

[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 of Rate Development and Analysis

LTC Provider Assessment

The Provider Assessment Program (Program) was implemented in July 1991. The Program makes use of a provision in federal law that allows states to claim federal financial participation (FFP) on payments for NF and ICF/IID services that are funded from the receipts of taxes paid by NFs and ICF/IIDs. These funds have helped the Department provide critical institutional services to some of the neediest and most frail Illinoisans. Funds generated by the Program are set forth below:

Fiscal Year	Nursing Facilities	ICF/IIDs
2014	$189.1	$19.1
2015	$186.5	$18.0
2016	$184.0	$17.5

**In millions*

Nursing Facilities

The Department has numerous responsibilities for NFs. It is responsible for developing NF policy in accordance with State and federal regulations, enrolling providers, and ensuring that sanctions set by IDPH are implemented. The Department works on a variety of billing issues such as ensuring that correct payments to providers are made by a system of ongoing pre- and post-payment review adjustments, entering bed hold data, providing billing assistance and information to providers, resolving billing discrepancies, and coordinating billing with the Department of Human Services (DHS) local offices. The Department further determines whether NFs meet the federal definition of an "Institution for Mental Diseases" for federal Medicaid claiming purposes and conducts onsite reviews at NFs to validate minimum Data Set (MDS) coding as it relates to reimbursement.

Nursing Facility Reimbursement

NFs are paid a per diem rate. There are three separate components to the per diem rate – nursing, capital, and support.

Capital & Support Component

Based on cost reports the NFs submit to the Department.

Nursing Component

Based on geographic location of the NF and the NF's case mix (average resident needs and service provided to each resident within the NF).

Effective January 1, 2014, the Department implemented the Federal RUG-IV 48 grouper methodology as directed by **Public Act 098-0104** to determine the NF case mix for the nursing component of the NF reimbursement. The individual needs of the patients and the actual services provided by the NFs are obtained from an MDS assessment performed quarterly by NFs for each Medicaid-eligible resident.

Under **89 Ill. Adm. Code 153.100**, nursing, support, and capital rate components are also based on changes unique to a NF:

- New NFs – New NFs do not have an established rate. For the nursing and support components of the rate, these NFs are given the median rate for their geographic area. The NF's capital costs are used to determine the capital portion of the rate.
- Capital – NFs that have increased building costs by more than 10% in the form of improvements or additional capacity may request an adjustment to the capital component of their rate. Capital exceptions resulted in rate changes for 81 facilities in FY 2016.
- Initial Cost Reports – Under certain circumstances, recently enrolled NFs 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 (6) NFs.

Certification/Decertification of Nursing Facilities and ICF/IIDs

During FY 2016, four (4) NFs and 12 ICF/IIDs voluntarily closed. 10 of the ICF/IIDs that closed converted to Community Integrated Living Arrangements (CILAs). All residents were relocated to appropriate settings. Four (4) new NFs and one (1) new ICF/IID were enrolled in the medical assistance program during this same period.

Improving LTC Application Timeliness

Public Act 98-0104 requires HFS and DHS to:

- ***Complete LTC eligibility determinations in a timely manner.***
  DHS has reorganized its process for LTC case processing into two (2) LTC hubs using specifically trained caseworkers to handle LTC processing of applications, admissions, redeterminations, and changes. Additionally, DHS and HFS utilize a database of pending LTC applications and admissions to ensure applications and admissions are tracked based on age and status. This combination of efforts and the work of DHS management and staff have reduced the number of pending applications from over 10,000 in January 2014 to 4,150 in February 2017. Applications pending with the HFS Office of Inspector General for resource review have dropped from almost 2,200 in January 2014 to 960 in February 2017. Applications pending more than 90 days have decreased from almost 6,000 in January 2014 to less than 2,000 in February 2017. DHS and HFS will continue to explore additional solutions to decrease LTC case processing timelines.

- ***Assess feasibility of incorporating all information needed to determine eligibility for LTC services, including asset transfer and spousal impoverishment, into the State's Integrated Eligibility System (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. The applicant has the opportunity to upload required verifications with the electronic submission of the Application for Benefit Eligibility (ABE). Development of a partner portal is progressing and will include the capability of a provider to upload required verifications pertinent to changes reported electronically. 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 streamlined LTC application process.***
  DHS and HFS representatives meet regularly to identify ways to streamline the application process. Training sessions on using the ABE application system were 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.

Home and Community-Based Services (HCBS) Waivers

In an effort to provide alternatives to NF placement, the Department, in collaboration with the Departments on Aging and Human Services and the University of Illinois, also offers care through nine (9) Home and Community-Based Services (HCBS) waiver programs. The nine (9) HCBS waivers serve 110,743 people. The Department, in its role as the single state Medicaid agency, provides administrative coordination, direction, oversight, program, fiscal, and quality monitoring for all nine (9) waivers.

HCBS waivers, authorized under 1915(c) of the Social Security Act, allow states to provide specialized, home or community-based long-term services and supports (LTSS) to individuals who would otherwise receive care in institutions. Each year, every waiver program must demonstrate that the cost of services for waiver participants is not more than the cost of serving the same population in an institution.

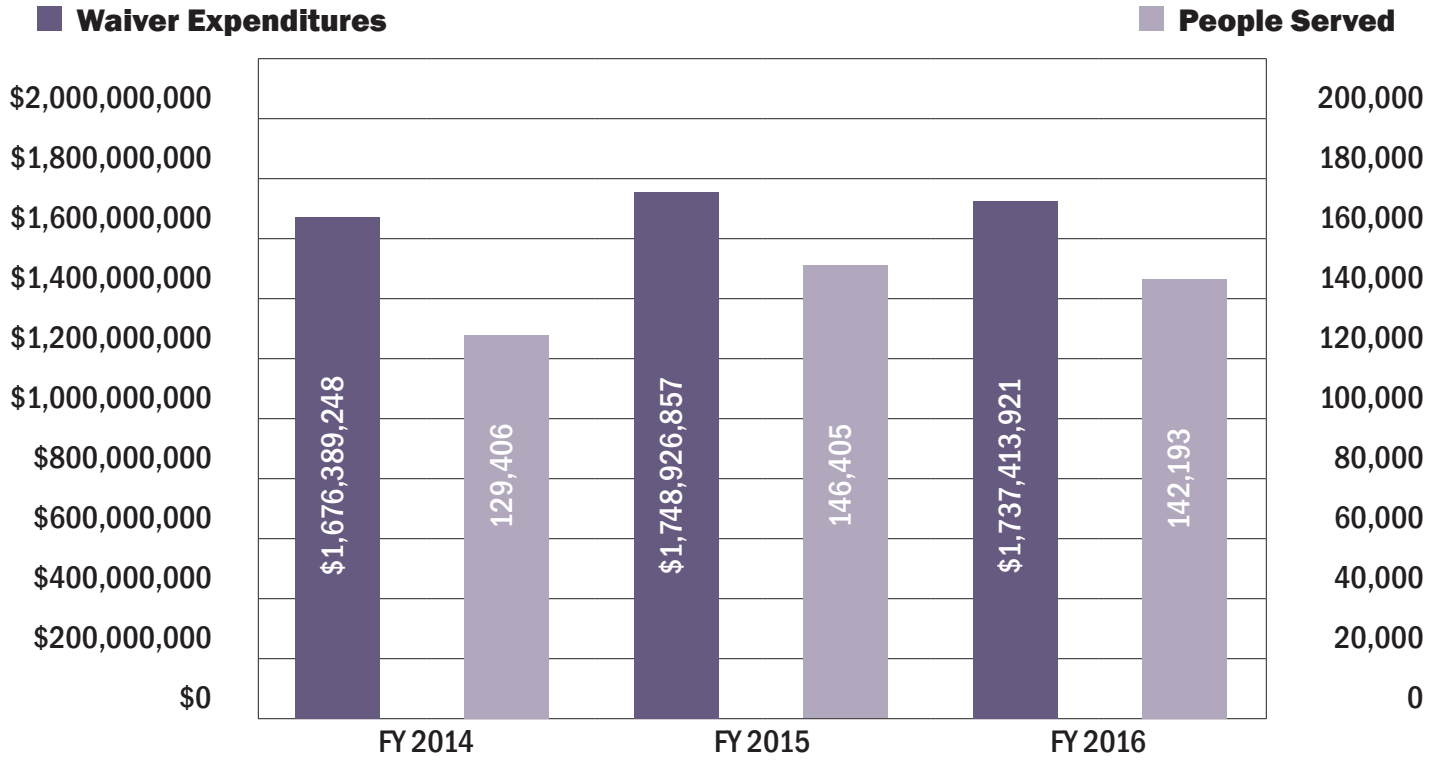
All but the supported living program waiver are operated by HFS' sister agencies through interagency agreements. Each waiver is designed for individuals with similar needs and offers a different set of services. The waivers and the operating agencies are:

Waiver	Operation Agency
Persons with HIV or AIDS	Department of Human Services (DHS) Division of Rehabilitation Services (DRS)
Persons with Brain Injuries	DHS-DRS
Persons with Disabilities	DHS-DRS
Adults with Developmental Disabilities	DHS-DRS
Children and Young Adults with Developmental Disabilities - Support	DHS Division of Developmental Disabilities (DDD)
Children and Young Adults with Developmental Disabilities-Residential	DHS-DDD
Persons who are Elderly	Department on Aging
Medically Fragile, Technology Dependent Children	University of Illinois at Chicago, Division of Specialized Care for Children (DSCC)
Supportive Living Program	HFS

See **https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx** for detailed information on each waiver.

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a rule (**42 CFR 441.301(c)**) related to HCBS waiver settings. This rule requires that any setting that provides HCBS waiver services demonstrate the characteristics of a community-based, rather than an institutional setting. As of the date of this report, March 31, 2017, States are required to bring provider settings into compliance with the rule by March 17, 2019. The Department has developed, with the HCBS waiver operating agencies and guidance from CMS, a Statewide transition plan to ensure proper roll out, implementation, and long term compliance with this rule. A copy of the Statewide transition plan can be found at **https://www.illinois.gov/hfs/MedicalClients/HCBS/Transition/Pages/default.aspx**.

Waiver Expenditures & Beneficiaries Served



Note: All data was 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. FY 2015 figures are preliminary and are expected to increase due to waiver expenditure data reported up to 18 months after expenditures are incurred

Quality Assurance

HFS holds quarterly meetings with the operating agencies on each waiver's quality improvement system and works closely with them, the federal government and, for some of the waivers, an HFS contractor. The Department's goal is to maximize the quality of life, functional independence, health, and well-being of Medicaid waiver participants through data analysis and systems improvements which follow rigorous federal quality improvement requirements. The State quality improvement strategies focus on performance measures, sampling, and a continuous quality improvement process (discovery, remediation, and system improvement).

LTC Rebalancing

Money Follows the Person

Money Follows the Person (MFP) is a federal demonstration program that provides participating states enhanced (an additional 25% to the regular match) federal Medicaid matching funds for their expenditures on HCBS to Medicaid clients transitioning out of institutional settings. States must use these enhanced funds to improve access to HCBS and for systemic improvements to their HCBS systems.

MFP was approved in 2008 (**Public Act 95-438**) and the first transition took place in 2009. Since its inception, Illinois has drawn more than $16 million in enhanced federal funding. Illinois has used these funds for several initiatives, including expansion of mental health services for clients who transition through MFP, bridge subsidies for MFP clients, and cross-population outreach to clients in institutions through the use of Transition Engagement Specialists.

Illinois' MFP program has led to important systemic changes to support efforts to rebalance the LTC system towards community-based care. 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 aid in the location of suitable housing for clients who wish to transition, the State implemented an online housing matching and wait list system and sought and received housing funding for MFP participants through the U.S. Department of Housing and Urban Development Section 811 supportive housing voucher program.

LTC and Home and Community-Based Services (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%
2016	$4,033,112,614	$1,844,756,004	45.74%

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.

As the State shifts its Medicaid program increasingly from a fee-for-service (FFS) to a managed care model, MFP has sought ways to work within the managed care model. In August 2016, the State began an incentive program that encourages managed care organizations to support MFP transitions. In addition, the Department is collaborating with managed care organizations on information sharing as a means of sustaining transitions after the MFP project ends.

Due to the expiration of the MFP program, MFP will stop accepting referrals on June 30, 2017 and will stop initiating participant transitions on December 31, 2017.

Visit the MFP website page at:
https://www.illinois.gov/hfs/MedicalPrograms/mfp/Pages/default.aspx.

Fiscal Year 2016 MFP Transitions by Service Population	
Population Group	**# Transitions**
Individuals who are Elderly	42
Individuals with a Physical Disability	42
Individuals with a Serious Mental Illness	21
Individuals with an Intellectual Disability	26
Colbert Class Members (cross population)	388
Total	**519**

MFP Transitions by Service Population CYs 2009-2016	
Individuals who are Elderly	402
Individuals with a Physical Disability	420
Individuals with a Serious Mental Illness	397
Individuals with an Intellectual Disability	316
Colbert Class Members (cross population)	1242
Total	**2,777**

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 LTSS. Illinois' BIP application was approved June 12, 2013. By participating in BIP, Illinois was able to capture a two (2)% increase (approximately $96 million) in federal Medicaid funding from July 1, 2013 through September 30, 2015. There has been an extension through September 30, 2017 to spend this enhanced match on approved activities as well as meet certain goals. With this enhanced federal funding, HFS, in collaboration with its sister agencies (DHS and DonA), is implementing three structural reforms required by the BIP:

No Wrong Door/Single Entry System: Clients who are interested in LTSS may contact any of the "no wrong door" sites, which includes a dedicated screening hotline, to be directed to the appropriate resources.

Conflict Free Case Management Services: "Conflict of interest" is defined as a "real or seeming incompatibility between one's private interests and one's public or fiduciary duties." CMS recommends several design elements to ensure conflict free case management. For more information on Illinois and other states, visit: **http://www.balancingincentiveprogram.org/sites/default/files/CFCM_State_Summary_2015.v2_0.pdf**.

Core Standardized Assessment Tool: A customized, comprehensive, internationally recognized instrument which will allow the State to create a more holistic view of each client and better guide clients to appropriate services and supports. Implementation planning efforts are underway to pilot the tool before a Statewide rollout in 2017.

Visit our BIP website for more information: **https://www.illinois.gov/hfs/MedicalPrograms/mfp/Pages/bip.aspx**.

CHAPTER 5

HOSPITAL SERVICES

HOSPITAL SERVICES

260 hospitals participated in the Illinois Medicaid program in Fiscal Year 2016

Hospitals are reimbursed for serving Medicaid clients in several ways, including:

- Inpatient Claims
- Outpatient Claims
- Disproportionate Share Hospital Payments
- Supplemental or Static Payments
  - Hospital Assessment-Funded Supplemental Payments
  - General Revenue Funds (GRF)-Funded Supplemental Static payments, including Transition payments held over from the pre-2014 payment system

Note: The payment and utilization data presented in this section is limited to payments for those individuals covered under fee-for-service (FFS) reimbursement and does not include those covered under a Medicaid managed care plan. With the transition of individuals from FFS into managed care plans, a significant reduction of FFS utilization and spending from 2015 to 2016 was expected. Further, these sections do not include data from the large government-owned hospitals. Those entities provide a portion of the State's share of reimbursement and are generally not paid with GRF. Hospital payments that are partially funded through hospital assessments, unless otherwise noted, are not included.

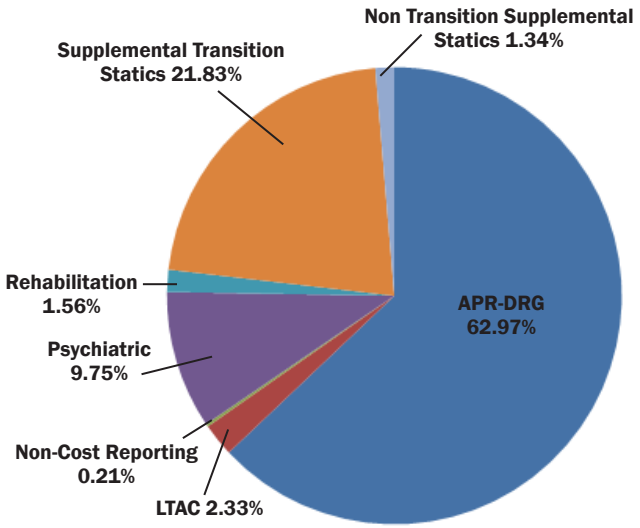
Inpatient Hospital Payments - GRF

Inpatient hospital claims consist of acuity based groupings – called All Patient Refined Diagnosis Related Groups (APR-DRG) – with several specialized, claims-based add-ons, including Disproportionate Share, Safety/Net, Psychiatric, Medicaid Percentage Adjustment, and Medicaid High Volume Adjustment. Some types of claims are excluded from APR-DRG and continue to be paid on a per diem basis, including psychiatric and rehabilitation hospital claims and services provided by long-term acute care (LTAC) hospitals and non-cost reporting hospitals.

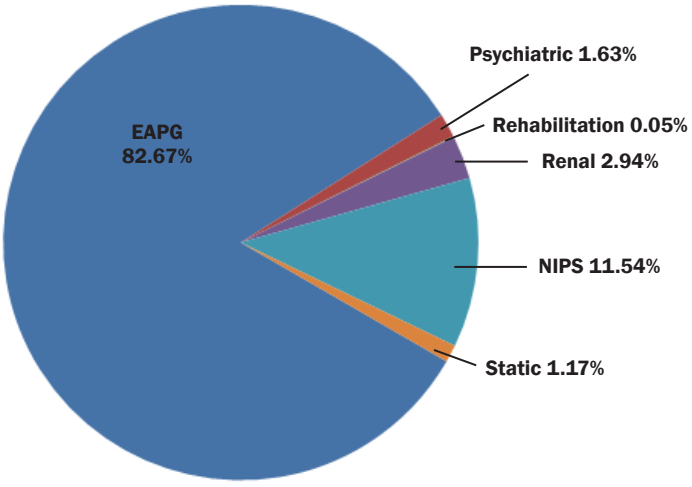
FY 2016 hospital inpatient liability outside of the Department's managed care contracts, including payments for both claims and GRF-funded supplement static payments, totaled $1.4 billion, a 26% drop from the $1.9 billion spent on FFS in 2015. This corresponds with a 17% reduction in general acute care admissions for the FFS population. The reductions in utilization and overall payments are directly tied to the movement of individuals into managed care. Of the nearly $500 million reduction in inpatient payments, only $8 million is attributable to a reduction in supplemental static payments, from $329 million to $321 million, and the remaining $475 million is due to less FFS utilization.

Nearly 63% of the $1.4 billion in FY 2016 hospital inpatient payments were made pursuant to the APR-DRG based system that was implemented July 1, 2014 (67% in FY 2015).

2016 GRF Hospital Inpatient Spending - $1.4 B



2016 GRF Hospital Outpatient Spending - $492.8 M



Outpatient or Ambulatory Care Hospital Payments–GRF

Effective July 1, 2014, the Department replaced the antiquated 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 the APR-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. This year's report is the first comparison of two years (FY 2015 & 2016) under the new EAPG system.

The continued movement to managed care resulted in the reduction of outpatient FFS claims by 26%, from $2.7 million in 2015 to $2.0 million in 2016, which resulted in a corresponding 31% decrease in FFS outpatient claim-based reimbursement. Total 2016 spending on institutional claims paid via the EAPG system was $416 million, down from the $607 million in 2015. As in 2015, $5.8 million in outpatient payments continued to be paid through monthly supplemental static payments in 2016.

Unlike inpatient spending, most hospital outpatient spending is for direct patient claims reimbursed through the EAPG, as well as some renal and non-institutional payments (NIP), while supplemental static payments accounted for only slightly over 1% of outpatient payments compared to 23.17% of inpatient payments.

Disproportionate Share Hospitals

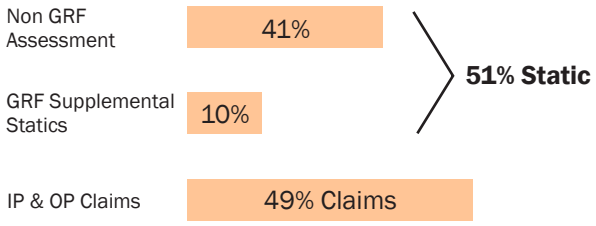
Federal law requires hospitals that serve a disproportionate number of low-income patients with special needs be given an appropriate increase in their inpatient rate or payment amount. Additionally, states are federally mandated to provide the increased payment to any hospital whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate or whose low income utilization rate exceeds 25%. In FY 2016, HFS expended the entirety of its federal Disproportionate Share Hospital (DSH) allotment of $233.6 million, which equated to about $459 million in total spending including state matching funds.

The following numbers of hospitals qualified for DSH in rate year 2016: 73 private (non-governmental) hospitals, including 10 which received DSH payments because they were within the federal guidelines set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1993; three (3) State-operated psychiatric hospitals qualified for DSH because their low income utilization rate exceeded 25%; and government-owned hospitals (University of Illinois Hospital and Cook County Hospitals and Health Systems). As federally-required, 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.

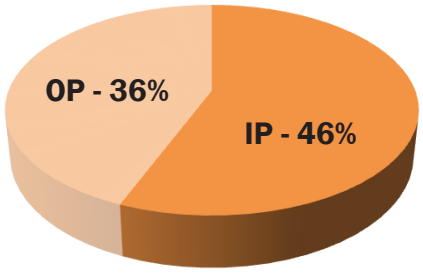
Non-GRF Funded Hospital Payments

The Hospital Provider Assessment Program was originally implemented in July 1991 and has been changed somewhat since that time. In accordance with Public Acts **95-0859**, **97-0688**, and **98-0104**, HFS is authorized to make hospital access improvement payments to qualifying hospitals. Instead of the State's portion of the payments being funded through the GRF, these payments utilize funding garnered through both an inpatient and outpatient assessment on Illinois hospitals. In total, nearly $2.4 billion in payments are made to the hospitals through both FFS payments and managed care capitation rates.

Total Hospital Payments
Claims vs Static



FY 2016 Hospital Payments
Inpatient vs Outpatient



Utilization Review & Quality Assurance

State Medicaid agencies are required to provide utilization review and quality assurance review in the inpatient hospital setting for services provided to FFS participants. The Department contracts with a federally designated quality improvement organization-like entity to provide these services. In FY 2016, non-certification of medically unnecessary services resulted in direct cost savings of $15.9 million.

CHAPTER 6

PHARMACY SERVICES

PHARMACY SERVICES

In accordance with federal Medicaid law, coverage of prescription drugs is limited to products made by companies that have signed rebate agreements with the Centers for Medicare and Medicaid Services (CMS). This encompasses the vast majority of pharmaceutical manufacturers. The Department of Healthcare and Family Services (Department, HFS or Agency) controls access to certain 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 Committee on Drugs and Therapeutics of the Illinois State Medical Society 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 (FY) 2016, the reimbursement rate for single-source medications (brand name) was Wholesale Acquisition Cost (WAC) or State Maximum Allowable Cost (SMAC) plus a dispensing fee of $2.40. Multi-source medications (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. Generic prescriptions comprised 88% of drug utilization.

The Department contracts with a vendor to develop and maintain a comprehensive listing of 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 (4) qualifying prescriptions in the preceding 30 days. Several classes of medications are exempt from the Four Prescription Policy, such as HIV (Human Immunodeficiency Virus) medications, oncology medications, antibiotics, over-the-counter medications, and diabetic testing supplies. 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 identify opportunities to improve efficacious drug therapy. Since inception of the policy, new utilization control edits have been implemented to address duplicate therapy, drug-drug interactions, inappropriate use, quantity, and duration of therapy. Additional information on the Four Prescription Policy is available on the Department's website at **https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/FourPrescriptionPolicy.aspx**.

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, oncology agents, and medications for orphan diseases. The goals of the specialty drug utilization controls are to encourage the use of the most cost effective medications where clinically appropriate and to 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 at **https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/Hemo.aspx**.

Preferred Drug List/Supplemental Rebate Program

The Department continues to develop and maintain a Preferred Drug List (PDL) at **https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/preferred/Pages/default.aspx**. Development of the PDL is based upon clinical efficacy, safety, and cost effectiveness. As part of the 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 Committee on Drugs and Therapeutics 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 FY 2016, the Department collected approximately $11 million in State supplemental rebates from drug manufacturers.

CHAPTER 7

OTHER COMMUNITY SERVICES & INITIATIVES

OTHER COMMUNITY SERVICES & INITIATIVES

MATERNAL AND CHILD HEALTH PROMOTION

The Department of Healthcare and Family Services (Department, HFS, or Agency) is committed to improving the health of women and children. HFS serves as an advocate in promoting wellness through a continuum of comprehensive health care programs that address such issues as social emotional development, immunizations, lead screening, and family case management. Improving the health status of mothers and children can be achieved through education, prevention, and partnerships with other programs. More information on the programs offered by HFS can be found at: **https://www.illinois.gov/hfs/MedicalClients/MaternalandChildHealth/Pages/default.aspx**.

The birth of over 80,000 babies are covered by the Department every year. See the perinatal report issued by HFS and the Illinois Department of Public Health (IDPH) on the status of prenatal and perinatal health care services: **https://www.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/report.aspx**.

Title IV of the Children's Health Insurance Program Reauthorization Act (CHIPRA)

Title IV of the Children's Health Insurance Program Reauthorization Act (CHIPRA), **Public Law 111-3**, seeks to improve access to and the quality of health care provided to children in both the Children's Health Insurance Program (CHIP) and Medicaid. Illinois partnered with Florida and received one (1) of 10 CHIPRA Quality Demonstration Grants. The grant was initially awarded for a five-year period from February 2010 through February 2015 and was extended through February 2016. At the conclusion of the CHIPRA grant period, the project activities were summarized in a final report, *Building on the CHIPRA Grant*
Experience to Spread and Sustain Quality Health Care for Children – Key Focus Areas and Sustainability Opportunities of the Florida-Illinois CHIPRA Quality Demonstration Grant, at **https://www.healthmanagement.com/wp-content/uploads/CHIPRA-Key-Focus-Report-Final.pdf**.

MENTAL HEALTH SERVICES

The Illinois behavioral health system continues to be heavily reliant on institutional care rather than community-based care. Approximately 40% of Illinois' Medicaid behavioral health spend is dedicated to inpatient or residential care which is significantly higher than the national average. This stands in sharp contrast to utilization of lower-cost community care, which is less than half the national average. This over-reliance on institutional care has significant implications for behavioral health members, who may experience additional stress due to removal from their communities and treatment in more restrictive institutional settings. Illinois is undertaking a significant transformation effort to integrate behavioral and physical health services and shift the system to be more community-based, see Chapter 2 of this report. Some of the earliest programs in this re-balancing and transformation effort are described below as well.

Screening, Assessment and Support Services (SASS) Program

The Children's Mental Health Act of 2003 (**Public Act 93-0495**) required the Department to develop protocols for screening and assessing children and youth prior to any admission to an inpatient hospital that is to be funded by the Medicaid program. In response to this requirement, HFS, in collaboration with the Departments of Children and Family Services (DCFS) and Human Services (DHS), developed the Screening, Assessment and Support Services (SASS) program. The SASS program model is built upon the core values and principles of systems of care which calls for an organized service system that emphasizes comprehensive, individualized, and culturally competent services provided in the least restrictive environment. The model calls for the full involvement of families in treatment and planning, interagency collaboration, a strengths-based approach, and care coordination at the community level to address children's needs.

In FY 2016, there were 16,217 unique children/ youth who experienced one (1) or more crisis events (18,245 total events) in FFS.

Since July 1, 2004, the SASS program has operated as a single, Statewide system serving children and youth who are experiencing a mental health crisis and whose care requires public funding from HFS, DCFS, or DHS. SASS operates 24 hours a day, 7 days a week and is responsible for the following for children and youth in fee-for-service (FFS): providing crisis intervention services; facilitating inpatient psychiatric hospitalization, when clinically appropriate; and providing case management and treatment services following a crisis event. SASS features a centralized point of intake known as the Crisis and Referral Entry System (CARES) Line. The CARES Line receives referrals for children and youth in crisis, determines whether the level of acuity meets the threshold of crisis, and refers the call to the most appropriate community resource, which may include the dispatch of a SASS crisis responder. In Fiscal Year (FY) 2016, the CARES Line received 125,153 calls, of which 117,923 were due to a crisis.

In FY 2016, the managed care system responded to 10,967 unique children/ youth in crisis (12,017 total events).

As the State's Medicaid infrastructure began to evolve through the introduction of care coordination and managed care service delivery systems, the State's approach to crisis response also had to evolve. Many of the children and youth traditionally served by the SASS program are now being served by Mobile Crisis Response (MCR) programs administered and funded by the various HFS-contracted managed care organizations (MCOs). MCR continues to feature centralized intake via the CARES Line and access to face-to-face crisis intervention services.

Psychiatric Consultation Phone Line — Illinois DocAssist

The Illinois DocAssist Program (DocAssist) is a Statewide psychiatry consultation and training service for primary care providers (PCP) or practitioners serving Medicaid enrolled children and youth under age 21. DocAssist is staffed by child and adolescent psychiatrists and allied medical professionals from the University of Illinois at Chicago, College of Pharmacy and College of Medicine - Department of Psychiatry. DocAssist seeks to meet the need for early and effective behavioral health (mental health or substance use) intervention for children and youth. The consultation services are provided directly by a child and

adolescent psychiatrist to an inquiring PCP 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 by offering targeted training and educational seminars on common child and adolescent behavioral health issues and makes resources available via the UIC supported web site: **http://www.psych.uic.edu/docassist/**.

Individualized Care Grant (ICG)

The Department began the transition of the Individual Care Grant (ICG) program from the Illinois Department of Human Services – Division of Mental Health (DHS-DMH) upon enactment of **Public Act 99-0479** in September 2015. The statute provided for a six (6) month transition period allowing HFS and DHS-DMH to work collaboratively on the transition while ensuring minimal disruption to participant services. During that time, HFS worked to develop a comprehensive understanding of historical developments and the design of the ICG program while concurrently analyzing the fundamental structures of the program. In an effort to retain continuity of care, HFS, through an intergovernmental agreement, retained the administrative services of Beacon/Value Options through FY 2016. During that time, HFS began to assume administrative control of the ICG program while developing a long-term implementation plan for ICG consistent with the State's efforts related to transformation.

As of June 30, 2016, there were 153 children eligible for ICG and almost two-thirds (2/3) were receiving services in the community.

Custody Relinquishment Prevention Act

Pursuant to the Custody Relinquishment Prevention Act (**20 ILCS 540/**, effective January 1, 2015), HFS entered into an interagency agreement with DCFS, DHS, Department of Juvenile Justice (DJJ), Department of Public Health (DPH), and the Illinois State Board of Education (ISBE) to identify the behavioral health needs of youth at risk of custody relinquishment and to link those youth to the most appropriate clinical services. The multi-agency agreement establishes the necessary infrastructure to identify and intercept families seeking intensive clinical services who may otherwise relinquish custody of their children to DCFS as a means of accessing treatment.

Illinois Choices Demonstration Project

The Illinois Choices Demonstration Project (Choices), established in FY 2015, continued services in FY 2016. Choices is a "Systems of Care" (SoC) demonstration pilot targeting children with significant behavioral health needs. Choices offers a tiered model of intensive care coordination, focusing on behavioral health services management for children enrolled in any of the full-benefit health programs administered by HFS in Champaign, Ford, Iroquois, and Vermilion counties. Choices enrollees are in FFS 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 funding, the Demonstration Risk Pool, which is used to purchase alternative services and alternative modes of service delivery for their enrollees.

In FY 2016, Choices successfully implemented their Mobile Crisis Response program for children in MCOs, replacing the State's existing SASS providers in the Demonstration area. In addition, Choices served 546 youth in their care coordination initiative while continuing to embrace the demonstration area and launched a series of provider meetings on potential services and new trainings to enhance the local service array and supports to families.

The website for Choices (**http://www.choicesccs.org/our-partners/illinois**) calls out the following successes: "Utilizing a team-based approach, youth and families receive the supports they need to be successful in their homes, schools, and communities." Youth served by Choices show improvement in school attendance, as well as family satisfaction with the care they receive.

LOCAL HEALTH DEPARTMENT PARTNERSHIPS

Through agreements signed individually between 78 local health departments (LHD) and the Department, HFS continues to maximize available federal resources by assessing and processing data on expenditures incurred by the LHDs in excess of State payments in order to determine which covered services rendered to Medicaid participants are eligible for federally matchable administrative expenses. This process brings in additional federal funds. The administrative expenses must be paid from local dollars and those dollars must not be used to match any federal awards. The additional funds are passed to the LHDs to provide resources for further expansion of services and increased access for Medicaid participants for such services as maternal and child preventive health and dental care.

DENTAL SERVICES

The FFS HFS Dental program is administered by DentaQuest of Illinois, LLC (DentaQuest). HFS, through DentaQuest, offers a comprehensive package of services to children, including preventative, diagnostic, and restorative services. For adults, the benefit is emergency only. 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.

DentaQuest reimburses dental providers in accordance with the Department's fee schedule, with weekly payments received from HFS based on the dollar amount of DentaQuest's adjudicated claims.
Link to Fee Schedule - https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Dental.aspx

FY 2016 Dental Payments			
	Number of Individuals	Dental Services	Payments
Individuals under 21	393,264	2.9 million	$86.8 million
Individuals over 21	143,333	970,000	$28.3 million
Total	**536,597**	**3,870,000**	**$115.1 million**

For more information regarding the HFS Dental Program, see the Department's Dental Program webpage at **https://www.illinois.gov/hfs/MedicalProviders/Dental/Pages/default.aspx** or contact DentaQuest at **www.DentaQuest.com** or 1-888-286-2447 (toll free).

Bright Smiles from Birth Program

HFS, in cooperation with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), has developed a Statewide Bright Smiles from Birth Program that uses a web-based training to educate physicians, nurse practitioners, and federally qualified health centers on how to perform oral health screenings, assessments, and fluoride and varnish applications. The program also gives guidance and makes referrals to dentists for necessary follow-up care and establishment of ongoing dental services. The initiative has proven successful in improving access to dental care and studies confirm that fluoride varnish applications are effective at reducing early childhood caries in young children. See **http://illinoisaap.org/projects/bright-smiles/** for more information.

REIMBURSING SCHOOL-BASED HEALTH SERVICES

Approximately 277,000 children received direct medical services through the school-based program during FY 2016. LEAs were reimbursed over $102.6 million for their costs to provide these services, as well as about $44.6 million for their administrative costs, including outreach.

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 (LEA) to receive Medicaid reimbursement for a portion of the costs incurred to provide direct medical services to Medicaid-enrolled children who have disabilities as defined under the federal Individuals with Disabilities Education Act (IDEA). For more information visit: **SBHS website**.

CHAPTER 8

PROGRAM INTEGRITY

PROGRAM INTEGRITY

The independent Office of the Inspector General (OIG) monitors the program integrity of the medical assistance program and related waiver programs. OIG's mission is to prevent, detect, and eliminate fraud, waste, abuse, misconduct, and mismanagement in programs administered by the Department of Healthcare and Family Services (Department, HFS or Agency) and Department of Human Services. In addition, the OIG ensures that the Department conforms to the federal requirements necessary to receive federal matching funds.

The OIG uses a custom built predictive modeling system called the "Dynamic Network Analysis" system (DNA) (highlighted as a Centers for Medicare and Medicaid Services "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. OIG actions include:

- **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 narcotics, but applicable to all medical services, 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, or prosecution by state and federal agencies.
- **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, 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 2016, the OIG successfully implemented legislative and enforcement initiatives that resulted in $220 million dollars in cost savings, avoidance, and recoupment for the taxpayers of Illinois. See the OIG annual reports at **http://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx**.

APPENDIX

CHARTS AND STATUTORY REQUIREMENTS

TABLE I - Mandatory and Optional Services

Federally Required Medical Assistance Services in FY 2016

The following services are required to be provided by HFS in the Medicaid, CHIP, and certain All Kids programs:

Certified pediatric and family nurse practitioner services

Emergency services

Emergency service for non-citizens

EPSDT: Early and Periodic Screening, Diagnostic and Treatment Services for individuals under age 21

Family planning services and supplies

Federally qualified health center services

Freestanding birth center services

Home health services

Inpatient hospital services

Laboratory and X-ray services

Medical/surgical services by a dentist

Nurse midwife services

Nursing facility services (age 21 and over)

Outpatient hospital services

Physician medical and surgical services

Rural health clinic services

Tobacco cessation counseling for pregnant women

Transportation to covered medical services

Optional Services Provided in FY 2016

The following services are covered by HFS in the Medicaid, CHIP, and certain All Kids programs but are not required to be covered under federal law:

Audiology services

Case management services

Certified Registered Nurse Anesthetist

Chiropractic services

Clinic services (Medicaid Option/Community Mental Health)

Clinical Nurse Specialist

Dental services, including dentures

Diagnostic services

Durable medical equipment and supplies

Eyeglasses

Home and Community-Based Services through federal waivers

Hospice services

Inpatient psychiatric services (IMD) for individuals 21 and under, including State-operated facilities

Intermediate care facility services for individuals with intellectual disabilities, including State-operated facilities

Nursing facility services for individuals under 21 years of age

Occupational therapy services

Optometric services

Physical therapy services

Podiatric services

Prescribed drugs

Preventive services

Prosthetic devices

Rehabilitative services (Medicaid Rehab Option)

Services provided through a managed care health plan

Special TB services

Speech, hearing and language therapy services

Transplant services

TABLE II

HFS MEDICAL ASSISTANCE PROGRAM Expenditures Against Appropriations - FY 2014 - 2016 *Dollars in Thousands*						
	FY 2014 Expenditures	**Percent**	**FY 2015 Expenditures**	**Percent**	**FY 2016 Expenditures**	**Percent**
Total[1,2]	**$10,424,131.9**	**100.0%**	**$12,151,126.2**	**100.0%**	**$12,259,335.6**	**100.0%**
Hospitals	**3,213,119.4**	**30.8%**	**2,751,533.0**	**22.6%**	**1,951,989.4**	**15.9%**
Long Term Care[3]	**1,784,454.3**	**17.1%**	**1,523,007.4**	**12.5%**	**1,436,222.5**	**11.7%**
Practitioners	**1,434,926.3**	**13.8%**	**1,101,345.1**	**9.1%**	**595,776.8**	**4.9%**
Physicians	1,131,432.0	10.9%	852,287.1	7.0%	456,333.7	3.7%
Dentists	250,903.6	2.4%	209,875.8	1.7%	116,545.6	1.0%
Optometrists	48,220.9	0.5%	35,593.0	0.3%	20,242.8	0.2%
Podiatrists	3,966.8	0.0%	3,303.0	0.0%	2,553.3	0.0%
Chiropractors	403.0	0.0%	286.2	0.0%	101.4	0.0%
Drug	**1,418,893.4**	**13.6%**	**1,288,947.4**	**10.6%**	**1,002,102.3**	**8.2%**
Other Medical	**1,254,221.9**	**12.0%**	**1,177,318.6**	**9.7%**	**1,065,740.0**	**8.7%**
Laboratories	67,468.5	0.6%	54,881.0	0.5%	34,970.4	0.3%
Transportation	79,834.3	0.8%	66,405.7	0.5%	49,423.5	0.4%
SMIB/HIB/ Expansion[4]	399,248.3	3.8%	405,292.2	3.3%	436,332.9	3.6%
Home Health Care/DSCC	128,439.1	1.2%	127,442.8	1.0%	126,815.9	1.0%
Appliances	80,484.9	0.8%	54,616.6	0.4%	47,456.2	0.4%
Other Related[5]	146,130.4	1.4%	170,811.6	1.4%	154,732.8	1.3%
Community Health Centers	263,999.0	2.5%	225,953.4	1.9%	143,577.9	1.2%
Hospice Care	88,617.4	0.9%	72,275.3	0.6%	72,403.4	0.6%
MCOs	**1,318,014.3**	**12.6%**	**4,308,974.7**	**35.5%**	**6,207,504.6**	**50.6%**
Children's Health Rebate	**502.3**	**0.0%**	**0.0**	**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 excludes FY 2016 administrative 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 enteral feeding tubes.

Table Prepared By: Division of Finance

Data Source: Division of Finance, Comptroller Spending Report FY 2016.

Annual Report Statutory Requirements

The Department issues this Annual Report under four statutory requirements:

Illinois Public Aid Code (305 ILCS 5/5-5) requires 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.

Illinois Public Aid Code (305 ILCS 5/5-5.8) requires 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.

Illinois Public Aid Code (305 ILCS 5/11-5.4) requires the Department to report to the General Assembly as part of the Medical Assistance Annual Report the status of applications for LTC services.

Disabilities Services Act of 2003 (20 ILCS 2407/55) requires 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 Department has 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.