ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

MEDICAID 101

Key Points

- 2.7 million adults and children are currently enrolled
- Most people covered are poor children – 1.7 of total
- Medicaid costs are highest for seniors and persons with disabilities – 16% of clients account for 55% of spending
- Medicaid is not Medicare – which is a 100% federally funded program, mostly for seniors
- Medicaid is jointly funded by federal and state government – 50%/50% in Illinois (varies by federal formula)
- Every state's Medicaid program must comply with federal law as well as its own state law

OVERVIEW OF MEDICAID CLIENTS

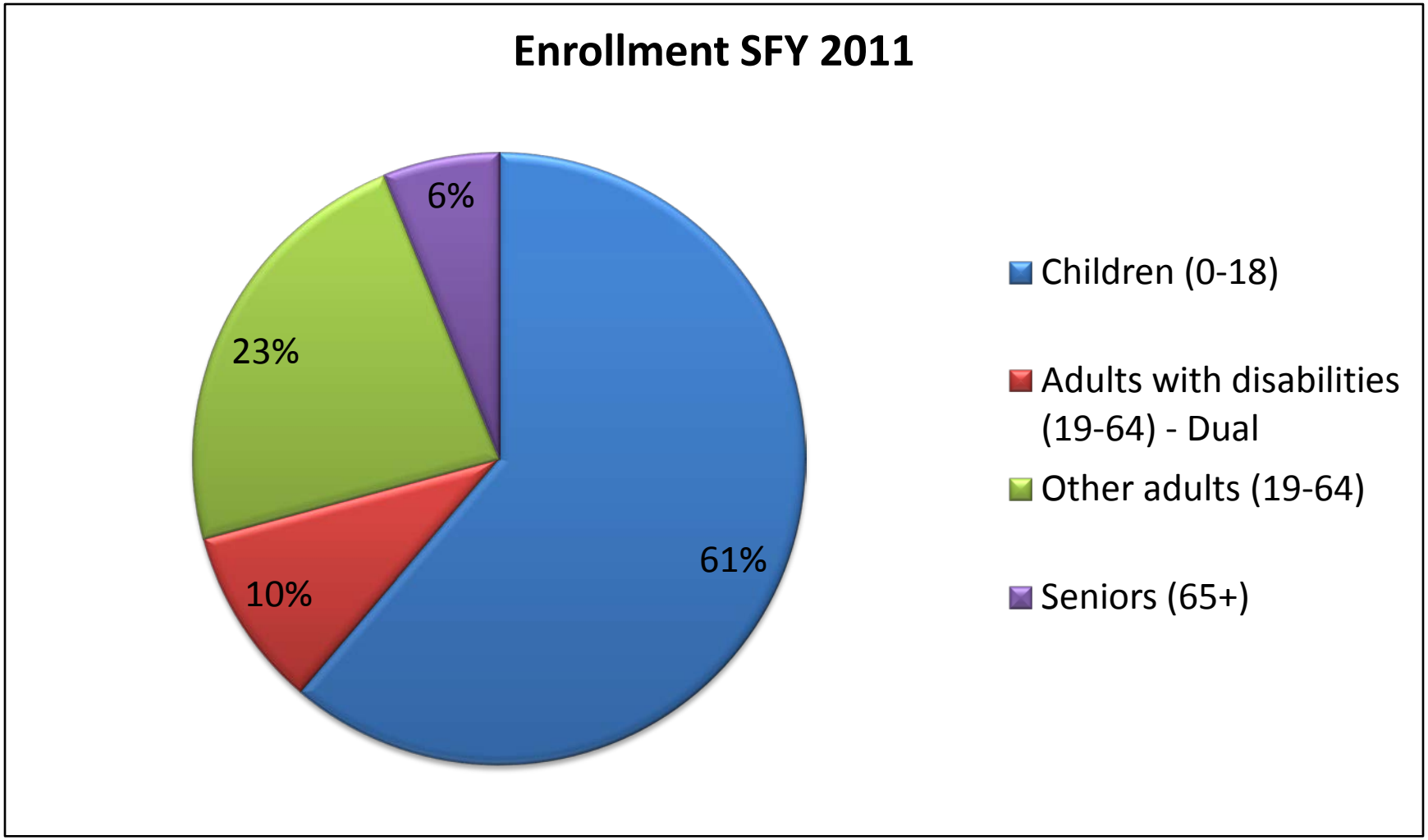
Our Clients

- Medicaid is healthcare for low-income Illinoisans
  - It is a “means-tested“ program: based on income
  - Also based on assets for some groups (e.g., disabled)
  - A person also has to fit into a category (see page 5)
- HFS pays for healthcare for different populations who do not qualify for Medicaid (no federal match)
  - Examples: Hemophiliacs and those not eligible for Medicare coverage of dialysis

Our Clients, cont'd.

- No matter how poor they are, today people must fit into certain categories to qualify for Medicaid:
  - Children under 19 (called "All Kids")
  - Persons with disabilities who meet the Social Security definition
  - Seniors aged 65 and older
  - Other adults
    - Parents and other caretakers of dependent children (called "FamilyCare")
    - Pregnant women (called "Moms and Babies")
      - About 53% of all births in Illinois were paid by Medicaid

Our Clients, cont'd.



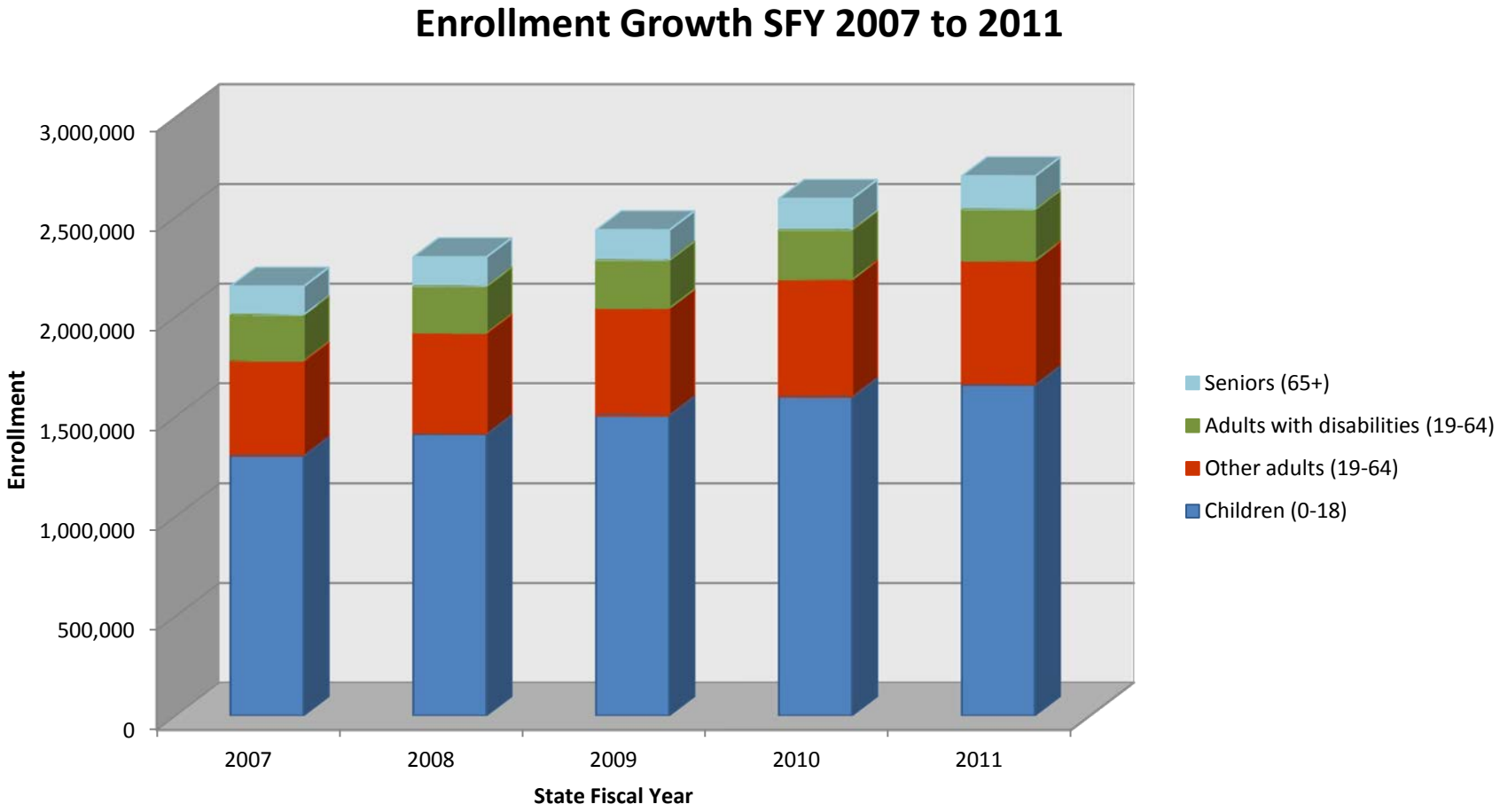
Our Clients, cont'd.

- After January, 2014, more people will qualify on basis of income (not categories), when the Affordable Care Act takes effect
  - Income level = 133% of federal poverty level (in 2012 about $25,390 per year or $2,116 per month for a family of 3)

Our Clients, cont'd.

- Enrollment has grown from 2.1 million clients in FY07 to 2.7 million in FY11 today
  - Children under 19 1,656,209
  - Adults with disabilities 258,672
  - Seniors 166,104
  - Other adults 623,807

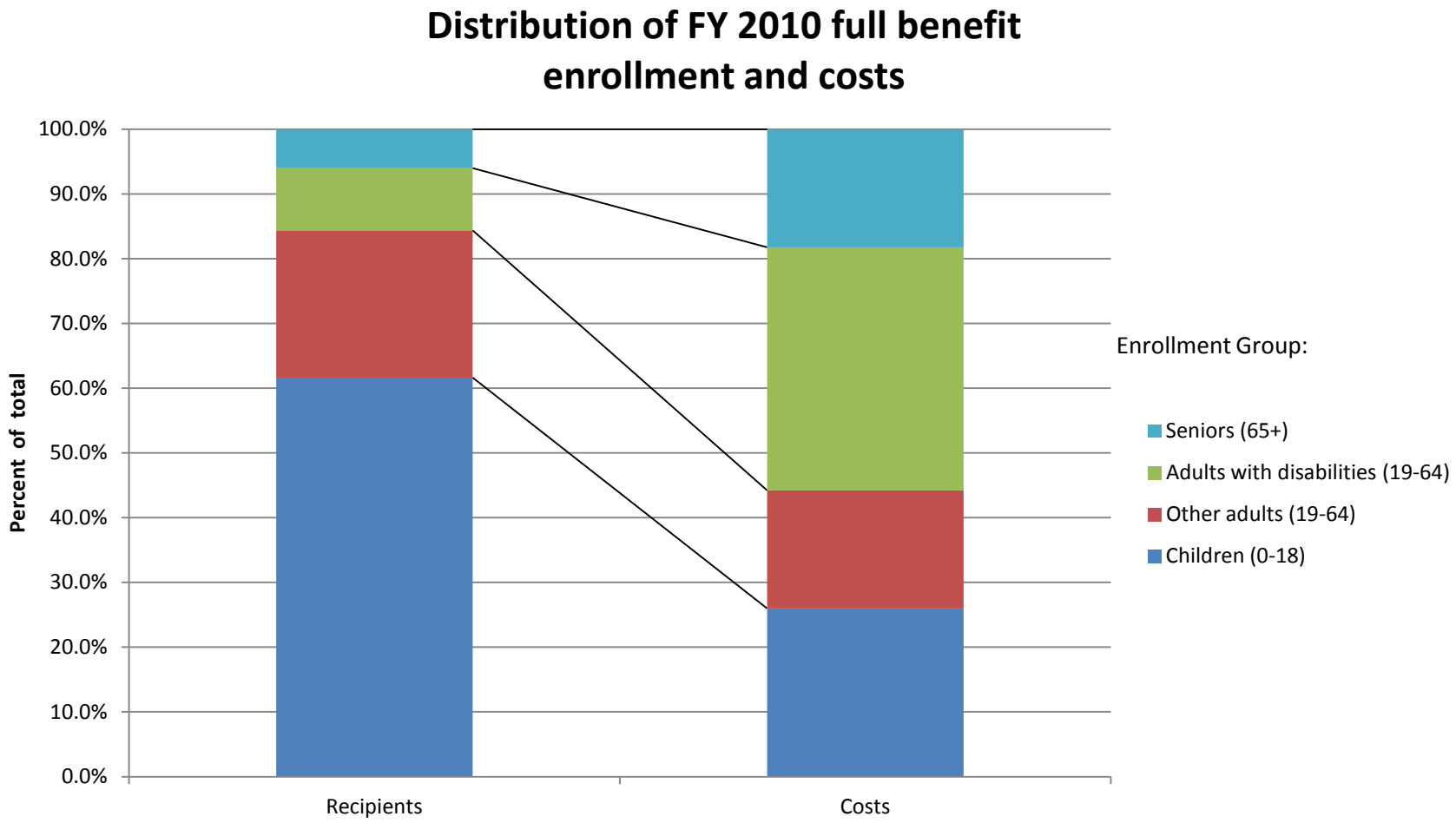
Enrollment Growth



Most Complex Clients

- 16% of clients who are Seniors and Persons with Disabilities (SPD) – about 420,000 clients – cost 55% of Medicaid budget (all agencies) – they have most complex health/behavioral health needs
- "Dual eligibles" qualify for both Medicare and Medicaid – about 261,000 of the 420,000 total
  - Medicare covers most healthcare costs, but Medicaid covers "long-term care" either in a nursing home or in a home- and community-based program — dual-eligible clients are typically much more expensive clients

Small % of Medicaid Clients Incur Majority of Medicaid Costs



Costs are paid claims for services provided during the fiscal year, inclusive of other agency spending and static payments

OVERVIEW OF MEDICAID PROGRAM & SERVICES

Program Overview

- In last 47 years, Medicaid programs mostly operated as a fee-for-service system, by:
  - Enrolling people
  - Giving them medical cards
  - Paying the bills
- Illinois Medicaid is one of last major states to operate primarily as fee-for-service – most states have implemented some form of managed care
- As fee-for-service, the system is fragmented and difficult to navigate for clients with complex needs, resulting in inefficient and wasteful spending

Program Overview, cont'd.

- Department of Healthcare and Family Services (HFS) is the Medicaid Single State Agency, accountable to the federal government
- HFS claims federal match for eligible Medicaid clients also served by:
  - Sister state agencies, such as the Dept. of Human Services (DHS), Dept. on Aging (DOA), Dept. of Children and Family Services (DCFS), including persons with mental illness, physical and intellectual disabilities, and seniors and in Medicaid's "home- and community-based waivers" – intended as alternatives to care in institutional settings
  - Local public health departments, Cook County Health & Hospitals Systems, State universities, local school districts' special education programs, etc.
- HFS is also accountable to the federal government for quality oversight of the entire program, including services in these other agencies

Services Covered

- For adults, many healthcare services are an entitlement and state Medicaid programs must pay when medically necessary
- But there are numerous “optional services”
  - Most “optional services” were added to the Medicaid program to substitute for higher cost services (pharmaceuticals, wheelchairs, etc.)
- For children, most healthcare services are an entitlement through “Early and Periodic Screening, Diagnosis and Treatment” (EPSDT) – whenever services are medically necessary

Major Medicaid Programs

- Illinois Health Connect: Over 1.8 million children and adults enrolled in Primary Care Case Management – a "medical home"
- Voluntary managed care: 200,000 children/parents have enrolled, now in 18 counties
- Mandatory managed care pilot: 40,000 seniors/disabled in suburbs, collar counties
- Nine home- and community-based "waivers" – mostly for disabled living at home or in community settings; seven administered by sister agencies

CURRENT REFORM EFFORTS

Preventing Client Fraud

- Client eligibility for Medicaid is conducted by Department of Human Services and HFS caseworkers
- 2011 Medicaid reform law (P.A. 96-1501) requires verification of one month of income, Illinois residency, to be conducted annually
- Federal "maintenance of effort" under ACA allows only limited changes in eligibility, and federal government created restrictions on state plans
  - Illinois has challenged federal impediments; working with feds to approve state law implementation

Status of Eligibility Verification

- For residency, now matching electronically with Secretary of State database
- For income, now using and will expand data matching with:
  - Department of Employment Security wage verification
  - Social Security Administration
  - SNAP and cash assistance (DHS)
  - Child support (HFS)
  - Department of Revenue tax records (new)
  - Income verification service vendor (new)

Preventing Provider Fraud

- Office of the Inspector General: investigations, audits, recoupments and sanctions
  - FY2011 – $70.8m in total recoupment/cost avoidance
  - 4:1 return on investment
- New initiatives include:
  - Recapture Audit Contractors (RAC)
  - Enhanced OIG predictive modeling system
  - Comprehensive integrity legislation

Redesigning Medicaid Delivery System

- Care coordination is centerpiece
  - Illinois Medicaid Reform Law (1/11) requires state to enroll 50% of Medicaid clients in “care coordination” by 1/1/15
- Rebalancing long-term care system will reduce reliance on expensive institutional care
  - Guided by 3 federal lawsuits, closure of state facilities
  - Need to build up community-based service infrastructure
- Reimbursement methodologies for hospitals and nursing homes must be modernized
- Transition from fee-for-service will require major changes for provider community and clients

Planning for Affordable Care Act

- Most provisions of ACA take effect January 1, 2014
- Additional 500,000 clients will qualify for Medicaid based on income (under 133% federal poverty level)
  - Federal government will pay 100% for “new” clients through 2017 and phase down to 90% by 2022
- Other Illinois initiatives include:
  - Work with General Assembly to approve new Health Benefits Exchange – health insurance for individuals and small businesses (100% federal funding for design of Exchange)
  - Integrated Eligibility System (IES) to overhaul antiquated computer system and integrate eligibility for Medicaid, Exchange, TANF, SNAP (90% federal funding)

MEDICAID BUDGET CRISIS

Medicaid Budget Overview

- Total HFS Medical Assistance budget is $14.2 billion
- Actual general revenue and related fund program liability is about $11.5 billion (all remaining amounts are in special funds)
- Medicaid-related bills are paid by HFS and other state agencies from their own budgets; HFS submits claims to federal government; federal match is returned to state's general fund or other funds (generally to fund from which original expenditure was made)
- Budget numbers for Medicaid are usually stated in "gross" numbers – that means total state and federal spending (as above); the state's portion ("net") is about 50%
  - Thus, every dollar of Medicaid budget authority removed only frees up 50 cents of State funding and foregoes 50 cents of federal revenue

Medicaid's Structural Deficit

- Illinois Medicaid currently has a $2.7 billion structural deficit
- For Medicaid, it is not enough to balance the budget by underfunding or under-appropriating
  - Without changing the law or rules to reduce overall liability and spending, the deficit continues to grow each year
- Liability and spending reductions must be voted on this spring, or HFS will have $4.7 billion of bills on hand by end of next fiscal year – that means many Medicaid providers will not be paid for 300 days!

How We Got Here

There are 4 reasons for the $2.7 billion structural deficit:

1) Deferral of Medicaid bills to future years for payment: Practice dates back at least 20 years; exacerbated last May when FY12 Medicaid budget was underfunded by nearly $2 billion

2) Federal stimulus enhanced match: Illinois received enhanced match of $1.2 billion per year since 10/1/08 – disappeared all at once last June

3) Fee-for-service system: Pays for quantity of services, resulting in inefficiency and waste

4) Significant enrollment growth during the national economic downturn

Plan for Addressing Medicaid Budget Crisis

- Ensure program integrity by preventing provider and client fraud
- Eliminate/reduce coverage of optional populations and optional services; redesign utilization controls, benefit packages
- Expand cost-sharing by clients
- Implement reimbursement reforms and, if necessary, provider rate reductions
- Redesign healthcare delivery system; accelerate care coordination
- Complete implementation of all reforms in Medicaid reform law

Why Is The FY13 Deficit $2.7 Billion?

(Dollars in Millions)

• **Growth in deferred bills during FY12 (underfunding)**	**$1,547**
– Unpaid bills grew from $314 million to $1.86 billion in FY12	
– Amount is needed to avoid a similar unpaid bill growth in FY13	
• **Plus: FY12 veto session revenues that don't repeat**	**$596**
– Gross spending of GRF deposits to the Healthcare Provider Relief Fund and the FY12 Hospital Provider Relief Fund	
• **Plus: Estimated FY13 base liability growth**	**$607**
– Actual increase in program costs (5.6% growth)	
• **Plus: High prior year lapse period spending that doesn't repeat**	**$303**
• **Plus: Net FY12 Medicare premiums paid via federal aid offset and elimination of FY11 unpaid bills at the Comptroller**	**$127**
– Medicare premiums paid from traditional appropriations in FY13	
• **Minus: Increased other funds resources in FY13**	**($495)**
– Greater other funds spending offsets GRF need	
• **TOTAL FY13 DEFICIT**	**$2,686**

Menu of Possible Options: Reducing "Optional" Populations

- Can reduce eligibility for children (All Kids) from 300% federal poverty level (FPL) to 200% FPL – savings of $21.7m
- Can reduce eligibility for parents/caregiver adults (FamilyCare) from 185% FPL to 133% FPL – savings of $49.9m
- Can eliminate eligibility for state-funded programs – savings of $188m
  - General Assistance adults – 9,160 clients
  - Undocumented children – 50,700 clients
  - Illinois Cares Rx – 177,000 clients (have Medicare Part D)
  - Kids with insurance (rebate) – 3,250 clients
  - Breast and Cervical Cancer Program uninsured women, in treatment – over 250% Federal Poverty Level – 380 clients
  - Torture victims – 60 clients
  - State Sexual Assault Program – 1,000 clients
  - State Renal Dialysis Program – 270 clients
  - State Hemophilia Program – 250 clients
  - State Non-Citizens Renal Dialysis Program – 700 clients

Menu of Possible Options: Eliminating "Optional" Services

- Can eliminate "optional services" – total savings of $1.9 billion
- Most of federal "optional services" were added to the Medicaid program to substitute for higher cost services
- Examples of optional services:
  - Hospice
  - Intermediate care in nursing facilities
  - Adult pharmaceuticals
  - Adult chiropractic
  - Adult dental
  - Adult occupational therapy services
  - Adult physical therapy services
  - Adult podiatric services
  - Adult speech, hearing, language therapy services
  - Adult durable medical services/supplies
  - Adult transplants
  - Adult eyeglasses limits

Menu of Possible Options: Utilization Controls

Examples of new utilization controls and cost sharing:

- Limit of 5 prescriptions per month
- Reducing potentially preventable readmissions in hospitals
- Hospital admissions for detox only when complications are present
- Prohibition on scheduled early term baby deliveries
- Moratoria on admissions to nursing homes for low-need clients
- No group psychotherapy for nursing home residents if outside facility
- Stricter rules for ambulance transports
- Evidence-based practices or elimination of bariatric (weight-loss) surgery
- New or increased co-pays for Federally Qualified Health Centers, Rural Health Clinics, non-emergency care in hospitals, private duty nursing

Budget Summary

- To achieve $2.7 billion liability and spending reductions, we would need to:
  - Eliminate ALL optional populations – $260 million
  - Eliminate ALL optional services – $1.9 billion
  - Impose new utilization controls/cost-sharing
- And it may still require some % of across-the-board provider rate cuts for Medicaid providers
  - Last year: 6% rate cut = $550 million
- Even with $2.7 billion in reductions, there will be $1.9 billion in bills on hand at end of June 30, 2013
- Without $2.7 billion in reductions, there will be $4.7 billion in bills on hand at end of June 30, 2013 – and Medicaid will collapse!