ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
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November 30, 2012

Tim Anderson
Secretary of the Senate
401 Capitol Building
Springfield, IL 62706

Dear Secretary Anderson:

Pursuant to the requirements of Illinois Compiled Statutes 30 ILCS 105/25, as amended, the following reports are attached:

- FY 2012 Expenditures for Services Provided in Prior Fiscal Years (Section (e)(i)) (Attachment 1).
- Medical Services for which Claims were Received in Prior Fiscal Years (Section (e)(ii)) (Attachment 2).
- Explanations of the causes of the variance between the previous year's estimated and actual liabilities (Section 25(g)(1)) (Attachment 3).
- Factors affecting the Department of Healthcare and Family Services liabilities, including but not limited to numbers of aid recipients, levels of medical service utilization by aid recipients, and inflation in the cost of medical services (Section 25(g)(2)) (Attachment 3).
- The results of the Department's Efforts to Combat Fraud and Abuse (Section 25(g)(3)) (Attachment 4).

If you have any questions, please contact Mr. Frank Kopel, Administrator, Division of Finance at (217) 524-7480.

Sincerely,

Julie Hamos

Julie Hamos
Director

JH/FK/td
Enclosures

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Timothy D. Mapes
Clerk of the House
420 Capitol Building
Springfield, IL 62706

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Julie Hamos
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Illinois Department of Healthcare and Family Services

Attachment 1

FY 2012 Medical Expenditures
For Services Provided in Prior Fiscal Years
Report Required under 30 ILCS 105/25(e)(i)
(in thousands)

Physicians	$77,656.7
Optometrists	1,716.5
Podiatrists	999.1
Chiropractors	100.9
Inpatient/Outpatient	268,491.3
Prescribed Drugs	106,517.1
Long Term Care - Geriatric	135,299.4
Institutions for Mental Disease	4,835.3
Supportive Living Facilities	3,792.6
Community Health Centers	10,767.3
Hospice	11,379.4
Laboratories	4,806.5
Home Health Care	8,346.3
Division of Specialized Care for Children	4,626.1
Appliances	9,799.9
Transportation	5,854.0
Other Related	8,589.7
Managed Care	12,127.2
Renal	155.1
Hemophilia Services	465.2
Sexual Assault Treatment	636.8
General Revenue and Related Subtotal	**$676,962.4**
University of Illinois - Hospital Services	24,919.2
County Provider Trust Fund (Cook County)	118,003.7
Special Education Medicaid Matching Fund	81,908.4
Juvenile Rehabilitation Medical Matching Services Fund	48.8
Medical Interagency Program Fund (including Children's Mental Health)	2,012.6
TOTAL	**$903,855.1**

Illinois Department of Healthcare and Family Services

Attachment 2

FY 2012 Medical Expenditures for Services Which
Claims were Received in Prior Fiscal Years
Report Required under 30 ILCS 105/25(e)(ii)
(in thousands)

Physicians	$3,033.2
Optometrists	112.4
Podiatrists	19.0
Chiropractors	2.9
Inpatient/Outpatient	13,616.4
Prescribed Drugs	34,472.7
Institutions for Mental Disease	1,275.1
Supportive Living Facilities	1,093.8
Community Health Centers	342.1
Hospice	1,785.3
Laboratories	1,033.4
Home Health Care	486.1
Appliances	1,576.2
Transportation	478.9
Other Related	1,394.4
Managed Care	1,116.1
Renal	18.0
Hemophilia Services	3.4
Sexual Assault Treatment	1.1
General Revenue and Related Subtotal	**$61,860.5**
University of Illinois - Hospital Services	920.4
County Provider Trust Fund (Cook County)	16,556.9
Medical Interagency Program Fund (including Children's Mental Health)	218.9
TOTAL	**$79,556.7**

Healthcare and Family Services
Explanation of Variance Between the Previous Year's Estimate and Actual Liabilities and Factors Affecting the Department's Liabilities
Required under 30 ILCS 105/25 (g)(1)(2)

1. **Explanation of the variance between the previous year's estimated and actual Section 25 liabilities.**

At the end of FY2011, the Department of Healthcare and Family Services' (HFS) Medical Assistance Section 25 liabilities were estimated to be $0.72 billion. After the close of FY2012, FY2011 actual Section 25 liabilities were $0.90 billion or approximately $185 million more than estimated. While higher than originally estimated, the Department's FY2011 Section 25 liability remains considerably lower than that experienced prior to the introduction of American Recovery and Reinvestment Act (ARRA) enhanced federal matching rates during FY2009 (see discussion below).

The difference between estimated and actual liabilities can be attributed to a variety of factors, including the use of historic trends between service dates and claim submittal dates. While these have been the most accurate methods for estimating liabilities, they will still produce minor degrees of variance from year to year.

In addition, there were two significant adjustments in the non-General Revenue Fund supported portion of the program that led to higher than estimated FY2011 Section 25 liabilities. First, the Department re-priced approximately $72 million in FY2009 and FY2010 school-based health claims, upon receipt of cost information from the local school districts and internal system modifications related to the enhanced ARRA federal matching rates. $30 million in retroactive FY2009 and FY2010 disproportionate share payments were also made to the Cook County Health and Hospital System. Since the payments to the local school districts resulted in a pass-through of 100% federal dollars and the net state share of the payments to Cook County was provided by the County, the prior period payment adjustments did not have a negative impact on the State's net cash position. The payments are reported as Section 25 liability simply because the payment mechanism utilized FY2012 state appropriation authority for prior year services.

As noted above, Illinois' federal matching rates for Title XIX Medicaid services were increased under ARRA beginning in FY2009. These enhanced match rate levels produced additional federal revenue that assisted the state in making Medical Assistance payments, leading to lower Section 25 liability than often experienced in prior fiscal years. ARRA requirements to pay hospitals and nursing homes within 30 days (in addition to the longstanding requirement to pay

medical practitioners within 30 days) also led to lower Section 25 liability than experienced prior to the stimulus.

2. Factors relating to HFS medical liability.

HFS continues to improve client access to quality healthcare and institute cost control measures to support consistent management of its annual Section 25 liability. During FY2011, the Department experienced 7.5% growth in its GRF and related fund liabilities due to enrollment growth, client utilization changes and the advancement of one month's nursing home liability into FY2011 (normally FY2012 liability) to maximize enhanced ARRA federal matching dollars per PA 96-1405. Absent that advancement of nursing home costs, FY2011 GRF and related program liability would have grown by approximately 6%. In FY2012, that liability is estimated to have remained relatively flat, but would have grown by approximately 2.8% if not for the aforementioned nursing home liability advancement into FY2011.

In FY2012, HFS provided access to full benefit health coverage for an average of approximately 2.8 million Illinoisans. Those receiving healthcare through the Department's program included almost 1.7 million children, about 644,000 adults without disabilities, 265,000 adults with disabilities and approximately 175,000 seniors.

In FY2011, HFS provided access to full benefit health coverage for approximately 2.7 million clients on average. Those receiving healthcare through the Department's program included almost 1.7 million children, about 625,000 adults without disabilities, 258,000 adults with disabilities and approximately 166,000 seniors.

HFS is working to improve health outcomes and the cost effectiveness of the Medical Assistance Program through various strategies. For example, the Department implemented the Integrated Care Program as part of its efforts to better coordinate healthcare and improve outcomes for its clients. Integrated Care is a program for older adults and adults with disabilities who are eligible for Medical Assistance, but not Medicare. It is a mandatory program for those clients living in suburban Cook and the collar counties. The program utilizes the concept of well-resourced medical homes with an emphasis on wellness, preventive care, evidence-based management of chronic health conditions and continuity of care. The two contracted companies offering Integrated Care health plans are financially rewarded for delivering quality healthcare services that result in better member health and cost reduction over time. As of October 2012, almost 36,000 individuals were enrolled in Integrated Care. The second phase of Integrated Care, offering long-term supports and services, is scheduled to begin in February 2013.

Recent Medicaid Reform efforts require even further advances in the area of coordinated care management. HFS is currently planning to meet the requirement that 50% of (or approximately 1.5 million) Medical Assistance clients be enrolled in a coordinated care program by January 1, 2015. Actually, it is the Department's goal to have 2/3 of our clients in care coordination by the 2015 deadline.

In Illinois, "care coordination" will be provided by three types of "managed care entities": traditional insurance-based Health Maintenance Organizations (HMO) accepting full-risk capitated payments; Managed Care Community Networks (MCCN), which are provider-organized entities accepting full-risk capitated payments; and Care Coordination Entities (CCE) which are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis. An initial group of six CCEs and MCCNs recently have been awarded contracts under HFS' Care Coordination Innovations Project; this program is expected to grow, based on interest and capacity by provider networks. In addition, a solicitation soon will be extended to CCEs and MCCNs for care coordination for children with complex health needs.

HFS' roll-out plan contemplates continuing enrollment into care coordination for different Medicaid populations, at various stages and in different geographies. The major roll-out plan has already begun with a focus on Seniors and Persons with Disabilities (SPDs), who comprise 16% of the Medicaid population but incur 55% of Medicaid costs. Accordingly, Illinois Medicaid is focusing on this population first, to provide more coordinated, effective health care to the clients who have the most complex health and behavioral health needs. These SPDs in the Medicaid Program will be enrolled with a managed care entity for the "medical service package," which includes medical and behavioral health services. In addition, those who need long-term care will also be enrolled with the same managed care entity for the "long-term supports and services" (LTSS) service package; this package may include care in a nursing facility or in the home, with assistance from the "home and community-based waiver" providers.

Some of the SPD population includes people who are on both Medicare and Medicaid (dual eligibles); we expect the federal government to partner with Illinois Medicaid to provide better coordination of services under the unique demonstration called the "Medicare-Medicaid Alignment Initiative". Medicare will continue to pay for the "medical service package" and Illinois Medicaid will continue pay for the "LTSS" service package, for those who need it; with a coordinated rate setting process that accounts for savings expected from enhanced care coordination by a managed care entity and better care.

In January 2014, Illinois Medicaid will expand the care coordination program to the other populations we serve: children, their parents, and newly-eligible

Medicaid enrollees under the Affordable Care Act (e.g. adults with no dependent children). It is expected that care coordination for these populations will be provided by some or all of the current managed care entities on contract with the state, as well as others who are likely to apply (including MCOs, CCEs and MCCNs). The traditional managed care organizations serving Illinois Medicaid clients are also likely to offer private health insurance on the Illinois Health Insurance Exchange, thereby providing continuity of care, as clients go on or off Medicaid.

HFS is also collaborating with providers and other stakeholders to redesign reimbursement systems for hospitals and nursing homes. In large part, current reimbursement structures reflect historical service levels and do not reflect changes in acuity levels or service needs. Reimbursement reform is critical to the success of the Department's coordinated care efforts in that cost savings will result from managing the care of high-cost clients only if hospital payments are based upon acuity and actual services provided.

HFS is actively participating with other state agencies in efforts to transition Medical Assistance clients from institutional to community-based care as appropriate. For instance, HFS was awarded enhanced federal match funding from the Money Follows the Person (MFP) demonstration project. At its core, MFP encourages states to shift the provision of long-term care services between institutional and community settings through the use of enhanced federal matching dollars on state expenditures for rebalancing efforts. MFP's goal, as with other long-term care rebalancing efforts, is to shift clients from nursing homes to community-based services funded by the Department of Human Services (DHS) and the Department on Aging. Moving clients out of institutional settings is expected to be a cost savings for the State, as community-based services are assumed to be less expensive.

The Department is also working with sister state agencies to implement judicial consent decrees involving the Williams, Ligas and Colbert class action lawsuits. These lawsuits challenged Illinois' use of institutional care for certain individuals with severe mental illness (Williams), developmental disabilities (Ligas) and those with disabilities (other than developmental disabilities) residing in skilled nursing facilities within Cook County (Colbert). Over the next few years, approximately 4,500 nursing home residents will need to be offered community-based services under Williams, at least 3,000 individuals under Ligas and 16,000 under Colbert.

As long-term care services are rebalanced under MFP, the consent decrees or other initiatives, then financial resources will shift from appropriations for institutional services (nursing homes) to community programs.

During spring 2012, HFS worked with the Governor's Office and the General Assembly to deal with an estimated $2.7 billion funding shortfall in the State's

Medical Assistance Program. That shortfall was addressed through a combination of new revenues, $1.6 billion in spending reductions and new Section 25 liability restrictions. Most of those actions were contained in PA 97-689, the Save Medicaid Access and Resources Together (SMART) Act. Since those actions are being implemented during FY2013, their impact on HFS' annual Section 25 liability will not be reflected until the report of FY2014 spending for services rendered in prior fiscal years. That report is statutorily required to be filed by November 30, 2014.

Attachment 4

Healthcare and Family Services
Results of the Department's Efforts to Combat Fraud and Abuse
Report Required under 30 ILCS 105/25 (g)(3)

All statistics are for FY2012 (7/1/11 to 6/30/12)

Providers

The HFS Office of the Inspector General (OIG) indentified $38.7 million dollars as a result of the completion of 265 provider audits through the audit administrative process for FY2012. Also during FY2012, the Department collected approximately $13.8 million from established overpayments determined by audits completed during or prior to FY2012.

These audits reviewed the billing practices of specific (selected) providers enrolled in the Medical Assistance Program. Providers' audits included individual practitioners, hospitals, nursing homes, pharmacies, laboratories, transportation entities and other provider types. The most common audit findings were missing records and improper billing procedure codes.

In FY2012, 18 medical providers were referred to the Medicaid Fraud Control Unit for investigation, 201 medical providers were terminated and 4 medical providers were suspended from the program due to the Department's program integrity efforts.

Clients

During FY2012, the Recipient Restriction Program restricted 441 clients who over utilized their medical privileges. Each client (254 for 12 months, 187 for 24 months) was restricted to a primary care physician and/or pharmacy. Cost avoidance savings for the clients' locked-in through the program for FY2012 was $1,396,892.

Employee/Provider Investigations

During FY2012, 5 complaints involving employee, provider or contractor fraud and abuse in the Medicaid Program were reviewed. 2 cases were substantiated, 2 cases were unsubstantiated and 1 case is still under investigation.