ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

JB Pritzker, Governor
Theresa Eagleson, HFS Director

FY 2018
ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

April 1, 2019

Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

A LETTER FROM THE DIRECTOR

Theresa Eagleson, Director

To the Honorable JB Pritzker, Governor, And Members of the General Assembly:

On behalf of the Department of Healthcare and Family Services (Department), I am pleased to present the Fiscal Year 2018 Annual Report of the Department's medical assistance programs, most commonly known as Medicaid, CHIP, and All Kids. Everyday, we are responsible for delivering quality healthcare to more than three million Illinoisans – one quarter of the state's population. They are among our most vulnerable individuals: Children, parents or relatives caring for children, pregnant women, veterans, seniors, eligible adults, persons who are blind and persons living with disabilities.

In FY 2018, the Department engaged a range of initiatives that we intend to build on and enhance. These included the launch of HealthChoice Illinois statewide, finalizing of a new Hospital Assessment Program, initiating 1115 Waiver programs, modernizing systems, moving forward on the development of Integrated Health Homes, and advances in telehealth.

This report provides details on specific initiatives, participant numbers, and provider reimbursement for Fiscal Year 2018 and, in some instances, the two previous years for purpose of comparisons and statutory requirements.

At the start of 2019, we began comprehensively evaluating and assessing our operations and are committed to engaging with all stakeholders to continually improve our practices. I hope you find this report informative and useful as we work together to ensure the Department brings the right care at the right time and place to all those we serve.

Sincerely,

Theresa Eagleson
Director

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CHAPTER 1

OVERVIEW

ABOUT HFS

The Department of Health care 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 2016	FY 2017	FY 2018
Children	1,490,290	1,462,872	1,434,972
Adults with Disabilities	249,241	246,813	264,519
Other Adults	607,827	592,850	553,918
Seniors	200,692	207,590	216,153
ACA Newly Eligible Adults	637,056	631,693	621,591
All Comprehensive	3,185,106	3,141,818	3,091,153
All Partial Benefits	16,486	17,187	34,328
Grand Total All Enrollees	**3,202,330**	**3,159,553**	**3,125,481**

HEALTH CARE PROGRAMS

The following are the health care programs provided by HFS. For more information about these programs and how to apply for the state funded only programs visit: https://abe.illinois.gov/abe/access/, the new portal to apply for and manage Medicaid and CHIP benefits.

All Kids Assist
Eligibility - Children up to 19 with family income at or below 147% of the Federal Poverty Limit (FPL) ($3,075 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 $3,076 and $3,284 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 $3,285 and $4,372 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 $4,373 and $6,652 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 19-25 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 $4,455 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 ($2,887 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 $1,396 for an individual or $1,893 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 ($1,012 for a single person and $1,372 for a couple) and no more than $2,000 of non-exempt resources for one person and $3,000 for the first two people and further increased by $50 for each additional dependent.
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 ($3,541 per month for an individual, $4,801 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 or resource test. **Presumptive Eligibility** - No **Benefit** - Comprehensive **Cost Sharing** - No

Health Benefits for Asylum Applicants and Torture Victims

Eligibility - Individuals 19 years of age and older 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 (a Social Security Number is not needed) 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 - There are three (3) programs for individuals eligible for Medicare Part A; Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI). Income limits vary per program; however, income is less than or equal to 135% FPL plus $25 (monthly SSI income disregard). Resource limits are $7,560 for a single person and $11,340 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 2018 (10/01/17 thru 09/30/18)

Client Hotline Numbers

Below are telephone numbers for use by beneficiaries of the Department's medical assistance programs.

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 2018, 18 cents of every dollar spent on Medicaid came from general State tax dollars.

PROGRAM COSTS

During FY 2018, HFS spent approximately $19.7 billion (all funds), of which $14.0 billion was from the General Revenue Fund (GRF) or GRF-related funds on enrollee health benefits and related services. (See Table II in appendix for HFS FY 2018 spending by appropriation line).

Medical Programs Spending

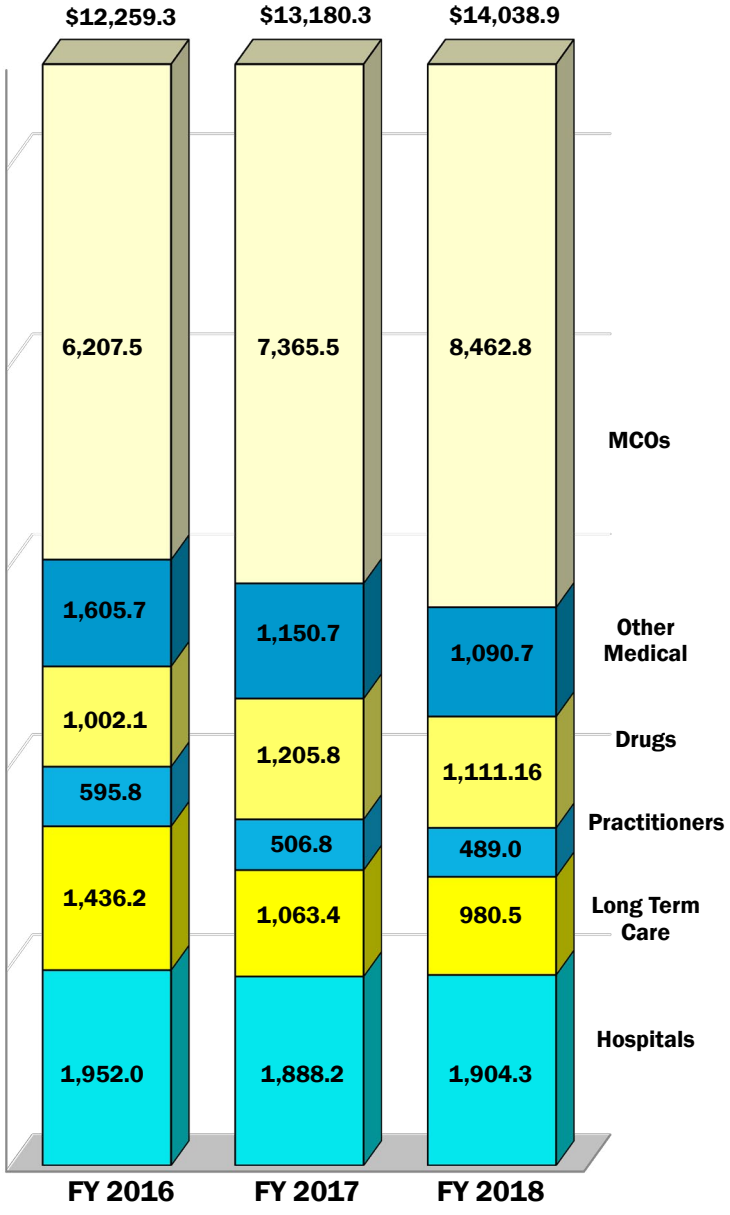
FY 2016 - 2018
Dollars in Millions

2016 - FY 2016 saw further conversion to mandatory managed care. Coordinated Care and Accountable Care Entities were phased out during the fiscal year. Within managed care programs, HFS is absorbing other agencies' FFS costs that are now included in the MCO capitated rates.

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

2017 - In FY 2017, MLTSS was introduced resulting in the transfer of prior FFS liability from other agency budgets. Other liability pressures include continued ACA growth and Medicare Part B and D increase driven by the federal government. Medicare A and B premiums continue to be paid via offsets to FFP draws.

2018 - Statewide mandatory managed care was introduced via new MCO contracts starting in the second half of the fiscal year. Other liability pressures include legislatively-mandated reimbursement changes in PA 100-0023 as well as continued growth in Medicare Part B and D driven by the federal government.



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 2018.

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

TRANSFORMATION

TRANSFORMING MEDICAL ASSISTANCE

When properly implemented, managed care offers Medicaid members enhanced health coordination and quality services at sustainable costs. While we are seeing the promise of these goals beginning to be met, we also understand that the previous administration did not adequately develop some components of the program, which we are working to correct as promptly and effectively as possible. The new administration is working closely with key stakeholders, including healthcare associations, hospitals, and other providers that rely heavily on Medicaid, to improve efficiencies around billing, payment, administration, and other systems. One of our highest priorities is introducing policies such as uniform billing guidelines and similar reforms to eliminate unnecessary payment delays and create more transparency in the program.

Managed Care

A primary focus of the state's transformation efforts has revolved around a more streamlined, accountable and integrated managed care program. The Department reissued a Request for Proposal (RFP) in February 2017, seeking out managed care organizations (MCOs) to improve the healthcare delivery for more than 2 million people, all while ensuring sustainable costs.

Awards were announced late summer/early fall of 2017. The risk-based contracts started January 2018 under the program name HealthChoice Illinois, with Medicaid clients having the opportunity to select one of five statewide (seven in Cook County) qualified and experienced managed care health plans. Existing membership began enrolling in the new program on January 2018; the second phase of enrollment, which expanded into new counties in Illinois, took effect April 2018.

Under the new program, close to 80% of Medicaid clients receive services through managed care, an increase of 15% from previous years. It also extended managed care to every county in Illinois.

See **Care Coordination** for more information.

1115 Federal Demonstration Waiver & State Plan Amendments

The goal of the 1115 waiver and any adjacent state plan amendments is to build a nation-leading behavioral health delivery system. This can be accomplished by rebalancing the behavioral health delivery system to reduce over-reliance on institutional care and shift to community-based care where appropriate; promoting integrated delivery of behavioral and physical health care; and providing infrastructure for achieving the goals of the N.B. v. Norwood consent decree. For more information, visit the transformation webpage at **https://www.illinois.gov/sites/hhstransformation/Pages/default.aspx**.

Technology Transformation

Developing a state-of-the art technology platform continued in FY 2018. This platform replaces a decades old system that inhibited efficient and effective reporting, analytics, and timely decision making. The new systems are designed to enhance program integrity and increase efficiency while reducing costs. Major system milestones include:

- Provider Enrollment System (enabling Uniform Credentialing)
- Integrated Eligibility System – Phases I & II
- Pharmacy Benefit Management System
- Medicaid Management Information System (IMPACT – Phase II)

CHAPTER 3

CARE COORDINATION

CARE COORDINATION

Overview

The Department has made significant progress since 2014 in transitioning its Medicaid population to a capitated managed care delivery system. As of January 1, 2019, approximately 76% of Illinois Medicaid beneficiaries were enrolled in comprehensive, risk-based managed care organizations (MCOs). For more enrollment information, visit the Department of Healthcare and Family Service's website at **https://www.illinois.gov/hfs/info/factsfigures/Pages/default.aspx**. This site provides enrollment by health plan by month, as well as a breakdown of enrollment by population type, percentage of members who actively selected a health plan vs. being auto assigned to a health plan, and member language preference. Data is updated monthly.

Transformation

During the first six months of FY 2018, the Department operated four MCO Programs: ICP, FHP/ ACA, MMAI, and MLTSS. In FY 2017, the Department began a series of transformations of its care coordination program. It implemented the Managed Long Term Services and Supports (MLTSS) program, a mandatory managed care program for dual eligibles (individuals enrolled in both the Medicare and Medicaid program) receiving long term services and supports who chose not to enroll in the Medicare-Medicaid Alignment Initiative (MMAI). In FY 2017, the Department also released a Request for Proposals (RFP), seeking services from qualified, experienced, and financially sound MCOs to enter into risk- based contracts to deliver health care to Medicaid enrollees.

Awards were announced in FY 2018 to five statewide managed care health plans (7 in Cook County), and enrollment began in the new HealthChoice Illinois contract on January 2018.

The new contract brought about some changes under managed care. It:

- Reduced the number of MCOs operating in Illinois from 12 to five (with two additional options in Cook County), making client selection less cumbersome.
- Expanded the managed care program to cover close to 80% of Medicaid beneficiaries, making managed care accessible in every county across the state. In previous years, managed care was available only in 30 counties.

- Increased the focus of quality, outcomes, accountability and care coordination. Concentrated oversight of the health plans included monthly, quarterly and annual business reviews, and daily account management activities.
- Streamlined procedures to better serve patient needs and providers, including uniform provider credentialing.
- Improved transparency and communication, including more provider notices about HealthChoice Illinois, enhancements to the care coordination website for providers, and health plan report cards for members.

HealthChoice Illinois helped realize the broad vision of an essential part of the Department's transformation, the 1115 federal demonstration waiver proposal, to better integrate physical and behavioral health care.

The MMAI program was not impacted by the HealthChoice Illinois RFP. As a three-way contract between the Department, federal CMS and the health plans, MMAI continued to operate and serve dual Medicaid-Medicare clients.

For more on HealthChoice Illinois, see HFS Care Coordination Website, which includes a section dedicated to members and helping them understand the benefits and how to enroll in managed care **https://www.illinois.gov/hfs/MedicalClients/ManagedCare/Pages/default.aspx**. There is also a section dedicated to providers **https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/defaultnew.aspx**. The HealthChoice Illinois model contract between HFS and the health plans can also be found here.

Phase-Out of Non-Risk Bearing Care Coordination

The Primary Care Case Management (PCCM) Program, Illinois Health Connect, provided care coordination statewide for individuals in counties where there was no mandatory participation in MCOs. The program terminated on December 31, 2017, with the implementation of HealthChoice Illinois, which expanded managed care into all counties statewide effective January 1, 2018. Individuals who were enrolled in the PCCM program were transitioned to a HealthChoice Illinois MCO.

Provider Complaint Portal

The expansion of managed care has meant that providers are continuing to learn to operate in a new environment and the MCOs and providers must continue to work together to resolve issues. To help address the payment and operations complaints in the provider community, the Department hosts the MCO Provider Complaint Portal at **https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/ManagedCareComplaints.aspx**. This secure electronic web-based portal is utilized after the provider has tried to resolve the issue with the MCO. Through the portal, provider's MCO complaints are reviewed and resolved promptly to ensure fair resolution of disputes between MCOs and providers. HFS continues to track and will publicly report the volume of complaints received and resolved by provider type, MCO, and other categories obtained from the portal to further enhance the managed care program in calendar year 2019.

Illinois Medicaid Plan Report Card

HFS has updated its consumer quality comparison tool, called the HealthChoice Illinois Plan Report Card, to reflect the performance of each of the seven HealthChoice Illinois MCOs that were operational in IL FY2018/CY2017. This report card is based on 2017 data for individuals in the Family Health Plan/Affordable Care Act (FHP/ACA) program and Integrated Care Program (ICP). In FY 2017, the MCOs had contracts per enrollee eligibility category. The report card helps individuals pick the health plan that is best for them by showing how each health plan does in providing care and services to their members for specific measures in key performance areas. The report card can be viewed in two formats. The first includes data for the seven health plans operating in Cook County. The second shows the five health plans operating outside of Cook County. The report cards show the trend of the data from the prior year, indicating if the health plan improved, stayed the same or got worse in each key performance area. The report card also shows how the health plans compare to national Medicaid ratings for each measure within key performance areas. The report card is posted at **https://www.illinois.gov/hfs/SiteCollectionDocuments/IL2018CY-2017HealthChoiceIllinoisReportCardStatewideandcookcountyFINAL.pdf**.

Benefits Provided by Non-MMAI MCOs

MCOs must offer the same comprehensive set of services that are available to the fee-for-service (FFS) population such as: physician and specialist care, emergency care, laboratory and x-rays, mental health, pharmacy, dental, vision, 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).

MLTSS enrollees (dual eligibles not enrolled in a MMAI plan) will receive some Medicaid-covered services from their MCO (e.g. 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, laboratories, x-rays, and medical supplies through Medicare FFS, Medicare Part D, or Medicare Advantage **See HealthChoice Illinois model contract between HFS and the MCOs for further detail on HealthChoice Illinois benefits.**

MCO Reimbursement

Capitation Rates: MCOs are reimbursed through capitation rates which the federal government must approve. Capitation rates are a fixed amount of money, commonly known as per member per month (PMPM) payments, which the Department pays monthly for the MCOs to assume full responsibility or risk for providing the Department's clients with health care services. The Department's actuary develops the MCO rates based on FFS claims experience, health plan claims experience, enrollment category, setting (e.g. nursing facility or HCBS waiver), and demographics such as age. Adjustments are made for health care management, trend, and health plan administration. All capitation rates must be actuarially sound per 42 CFR 438.4(a). Rates may be updated periodically to reflect future time periods, additional service packages, additional populations, or changes that affect the cost of providing covered services that the Department determines to be actuarially significant.

Pay for Performance (P4P) Measures: In addition to capitation rates, the HealthChoice Illinois contracts have pay for performance (P4P) measures to incentivize spending on care that produces health quality-of-life outcomes. P4P measures are ensured by withholding a percentage amount (Withhold) from the MCO's capitation rate. The MCOs can earn back the Withhold by meeting or exceeding the goals set by the P4P measures.

There was no withhold for the first calendar year (CY 2018) of the contracts. P4P measures for the remaining years will be funded through a withhold that began January 1, 2019. Measures were negotiated between the MCOs and HFS to determine which measures promoted the goals of the contracts.

Medical Loss Ratio (MLR): MLR means that MCOs must utilize a defined percentage of its capitation rates for health care services, quality improvement, and administrative costs. Under the HealthChoice Illinois reboot, the MLR was 85% (a minimum of 85% must be spent on health care services and quality improvements, and a maximum of 15% must be spent on administrative costs).

MMAI Demonstration Program for Dual Eligibles

Benefits: Dual eligibles are persons enrolled in both the Medicare and Medicaid programs. The MMAI contract is a three-way contract among CMS, HFS, and each MCO to provide health care services to dual eligibles. In MMAI MCOs, dual eligibles 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. See the HFS MMAI website at **https://www.illinois.gov/hfs/MedicalProviders/cc/mmai/Pages/default.aspx**.

MMAI MCO Reimbursement: Both CMS and HFS contribute to the global 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 are risk adjusted using the prevailing CMS risk adjustment models. The Medicaid rate component is adjusted based on an enrollee's age, geographic service area, and care setting (nursing facility, waiver, or community), and include a Long Term Services and Supports (LTSS) blended rate based on the nursing facility and waiver enrollment mix in each MCO at the beginning of the calendar year. The nursing facility portion of the blended LTSS rate is risk adjusted.

P4P: 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 on a combination of core quality withhold measures across all demonstrations nationally as well as Illinois-specific 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. Enrollees are stratified by risk level: low, moderate, and high. There is outreach and intervention at each level -- the higher the risk, the more outreach and intervention.

MCO Program Information

HealthChoice Illinois **Enrollees:** Children and their families, ACA adults, seniors and persons with disabilities and dual eligible age 21 and over who are eligible for both Medicare and Medicaid services, have opted out of MMAI and receive LTSS **Geographic Service Area:** Statewide **Mandatory Enrollment:** Yes	**Health Plans**	**June 2018 Enrollment**
	Blue Cross/Blue Shield of Illinois	454,048
	CountyCare Health Plan	329,387
	Harmony Health Plan of Illinois	252,888
	IlliniCare Health Plan Inc.	324,318
	Meridian Health Plan Inc.	572,889
	Molina Healthcare of Illinois Inc,	214,995
	NextLevel Health	58,932
	Total Health Plan Enrollment	**2,207,457**

MMAI **Enrollees:** Dual eligibles, 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	**Health Plans**	**June 2018 Enrollment**
	Aetna Better Health Inc.	6,973
	Blue Cross/Blue Shield of Illinois	19,461
	Humana-Health Plan	7,858
	IlliniCare Health Plan Inc.	7,214
	Meridian Health Plan Inc.	7,520
	Molina Healthcare of Illinois	3,659
	Total Health Plan Enrollment	**52,685**

Total MCO Program	**Health Plans**	**June 2018 Enrollment**
MMAI	Aetna Better Health Inc.	6,973
HealthChoice Illinois, MMAI	Blue Cross/Blue Shield of Illinois	473,509
HealthChoice Illinois	CountryCare Health Plan	329,387
HealthChoice Illinois	Harmony Health Plan of Illinois Inc.	252,888
MMAI	Humana Health Plan	7,858
HealthChoice Illinois, MMAI	IlliniCare Health Plan Inc.	331,532
HealthChoice Illinois, MMAI	Meridian Health Plan Inc.	580,409
HealthChoice Illinois, MMAI	Molina Healthcare of Illinois Inc.	218,654
HealthCHoice Illinois	NextLevel Health	58,932
	Total MCO Enrollment	**2,260,142**

Quality Assurance

State Quality Assessment and Performance

Improvement Strategy for Managed Care

The Illinois Department of Healthcare and Family Services (HFS or the Department) developed Partnering for Performance: Making the Choice for Quality as its Medicaid Comprehensive Medical Programs Quality Strategy (Quality Strategy) in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.340 et seq.

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 the state's 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 eight (8) goals identified in the box at the right.

8 Goals of Quality Strategy

Goal 1

Improve population health;

Goal 2

Improve access to care (including community-based long term services and supports);

Goal 3

Increase effective coordination of care;

Goal 4

Improve participation in preventive care and screenings;

Goal 5

Promote integration of behavioral and physical health care;

Goal 6

Create consumer-centric healthcare delivery system;

Goal 7

Transition to value and outcome based payment; and

Goal 8

Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHR) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration.

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):

- Validation of performance measures (in accordance with §438.358(b)(2));
- Compliance monitoring (as set forth in 42 CFR 438.358);
- Validation of performance improvement projects (PIPs) (for compliance with requirements set forth in 42 CFR 438.330[b][1]).

HFS' EQRO conducts an annual mandated review using CMS protocols to assess the completeness of the Quality Strategy, activities include:

- 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)
- 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.

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**. For information on LTSS in the managed care delivery system, see **Care Coordination**.

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 four (4) basic types of institutional settings in the LTC program: NF, Specialized Mental Health Rehabilitation Facilities (SMHRFs), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and Skilled Care for Individuals with Intellectual Disabilities.

Number of Facilities & Number of Beneficiaries Served

Nursing Facilities (NF):

- 697 NF
- Averaged just over 48,300 beneficiaries served in FY 2018

Specialized Mental Health Rehabilitation Facilities (SMHRFs)

- 24 SMHRFs
- Just under 4,000 beneficiaries served in FY 2018

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

- 222 ICF/IIDs
- Just under 5,000 beneficiaries served in FY 2018

Licensed & Medicaid Certified LTC Beds
Fiscal Year 2018 Actual

Level of Care	Medicaid Certified Beds[1]	Licensed Beds[2]
Skilled Care	70,424	80,224
Specialized Mental Health Rehabilitation Facilities (SMHRFs)	0	4,468
Intermediate Care (ICF)	9,653	9,960
Intermediate Care for Individuals with Intellectual Disabilities	4,580	4,580
Skilled Care for Individuals with Intellectual Disabilities	932	932
Total	**85,589**	**100,164**

[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, the MC/DD Act, the ID/DD Community Care Act, and provisional licensure through the Specialized Mental Health Rehabilitation Act of 2013.
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 Liability on Claims Received
Fiscal Year 2016 - 2018

Long Term Care - Total				
	FY 2016	FY 2017	FY 2018	% Change FY 2016 to FY 2018
Total HFS Liability[1] ($ Millions)	$1,472.72	$1,164.92	$1,033.81	-29.80%
Total Patient Days (Millions)	14.13	10.73	8.82	-37.58%
Weighted Average Rate[2] Per-Diem	$104.23	$108.57	$117.26	12.5%
Average Payment (Charge) Per-Diem[3]	$138.33	$141.05	$143.59	3.8%

[1]Reflects date of service liability and excludes capitated managed care reimbursements.
[2]Excludes patient contributions and third party payments.
[3]Geriatic only per diem for FY 2018 is $154.02. Chart includes Skilled, ICF, and SLP waiver.
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
2015	$186.5	$18.0
2016	$184.0	$17.5
2017	$183.7	$16.7
2018	$181.5	$16.9

**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

In the HFS fee for service program, 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 2018 eight (8) NFs and four (4) ICF/IIDs voluntarily closed. Seven (7) NFs closed due to financial hardship and one (1) closed due to decreased need. Three (3) ICF/IID converted to a Community Integrated Living Arrangement (CILA) and one (1) closed due to financial hardship. All residents were relocated to appropriate settings. None (0) new NFs and none (0) new ICF/IIDs were enrolled in the medical assistance program during this same period.

No New Enrollments for FF or ICF/IID Improving LTC Application Timeliness

Public Act 98-0104 requires HFS and DHS to:

- ***Complete LTC eligibility determinations in a timely manner.***
  DHS has further reorganized its process for LTC case processing by adding a third LTC hub containing specifically trained caseworkers to handle LTC processing of applications, admissions, redeterminations, and changes. DHS and HFS continue to 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 applications pending more than 90 days from over 10,000 in January 2014 to 5,389 in December 2017. Applications pending with the HFS Office of Inspector General for resource review were 1,048 in December 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 continues to explore 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 continues to have the opportunity to upload required verifications with the electronic submission of the Application for Benefit Eligibility (ABE). Development of a partner portal continues to progress 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.

- ***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 continues to incorporate 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 served 86,466 people in state fiscal year 2018. 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.

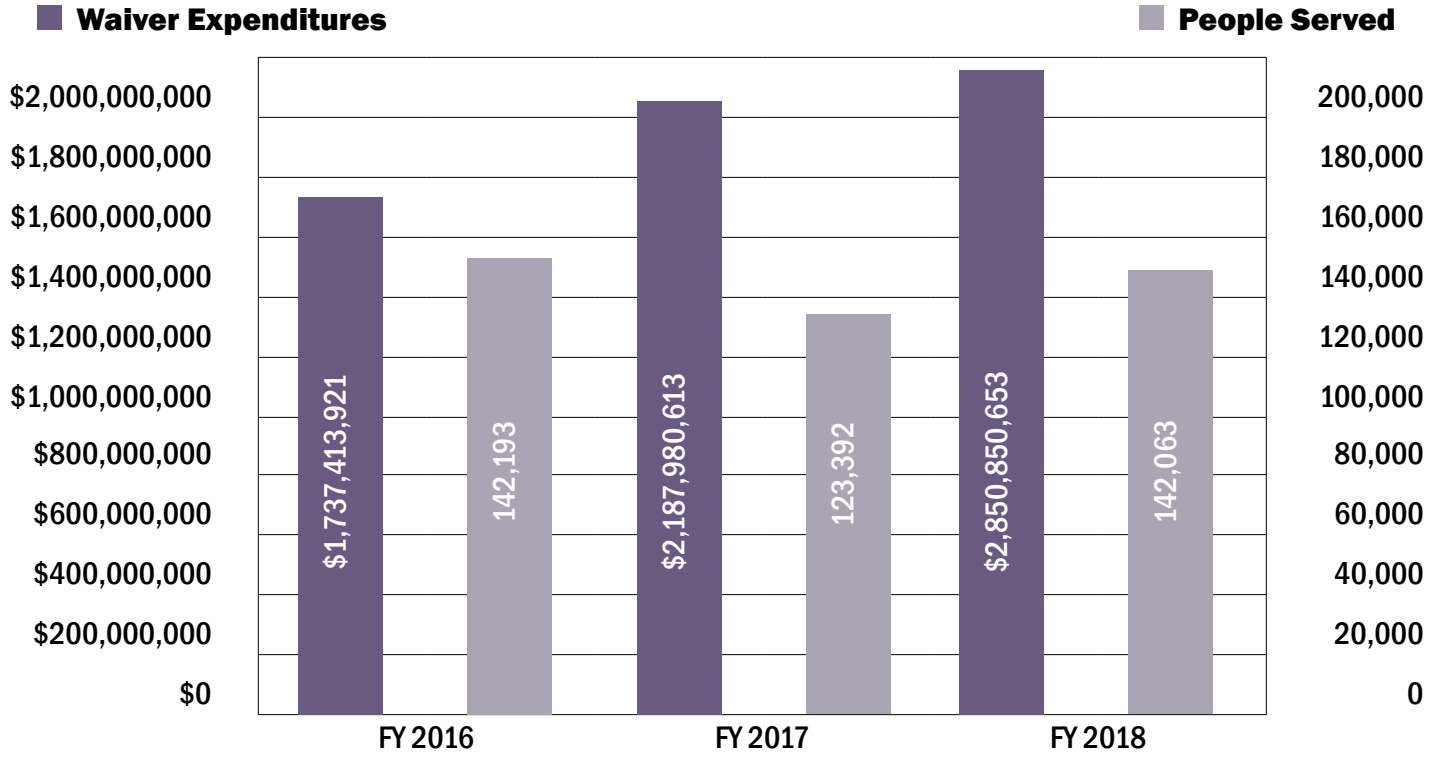
All but the supportive living program waiver are operated by non-HFS state agencies through interagency agreements. Each waiver is designed for individuals with similar needs and offers a different set of services. The waivers and the operating agencies are:

Waiver	Operating 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-Division of Developmental Disabilities (DDD)
Children and Young Adults with Developmental Disabilities - Support	DHS-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. 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 the Enterprise Data Warehouse (EDW) FY 2018 figures are preliminary and are expected to increase due to waiver expenditure data reported up to 18 months after expenditures are incurred

Quality Assurance

In collaboration with our sister agencies, HFS operates a formal, comprehensive quality assurance system to ensure the HCBS waivers support the State's goal to maximize quality of life, functional independence, health, safety, and the well-being of Medicaid waiver participants. Following rigorous federal requirements, the continuous HFS quality improvement process of discovery, remediation and system improvement promotes the health, safety and welfare of participants by monitoring performance measures, analyzing patterns and trends, and establishing systemic enhancements. 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 contracted vendor.

LTC Rebalancing

Money Follows the Person

Money Follows the Person (MFP) was a federal demonstration program that provided 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 were required to use these enhanced funds to improve access to HCBS and for systemic improvements to their HCBS systems. The MFP program was phased out. MFP stopped accepting referrals on June 30, 2017 and ceased initiating participant transitions on December 31, 2017.

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%
2017	$3,575,144,457	$1,650,610,488	46.17%
2018	$3,621,178,629	$1,719,559,617	47%

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

Balancing Incentive Program

The federal Balancing Incentive Program (BIP), authorized by the Affordable Care Act, incentivizes states to increase access to home and community-based 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, 2018 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 DoA), 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**.

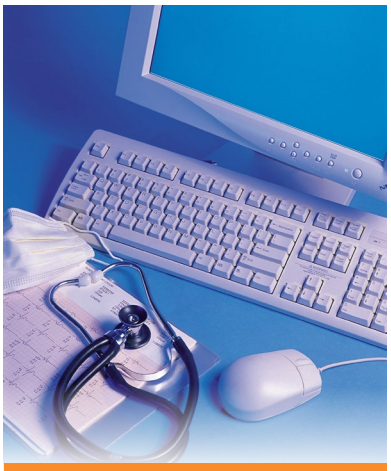
Core Standardized Assessment Tool: A customized, comprehensive, internationally recognized instrument which will allow the State to create a more holistic view of each client and better guide clients to appropriate services and supports. Implementation planning regarding the tool's use and potential rollout continues.

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

CHAPTER 5

HOSPITAL SERVICES

HOSPITAL SERVICES



257 hospitals participated in the Illinois Medicaid program in Fiscal Year 2018

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 2017 to 2018 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. The data presented herein is reflective of the final year to the new hospital assessment that took effect July 1, 2018.

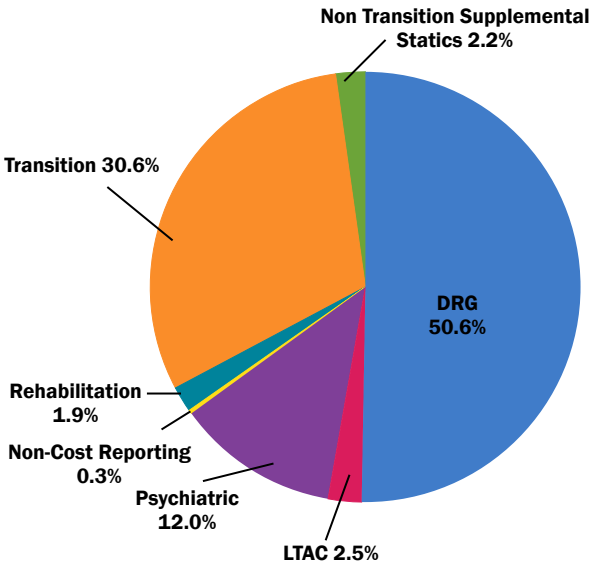
Inpatient Hospital Payments - GRF

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.

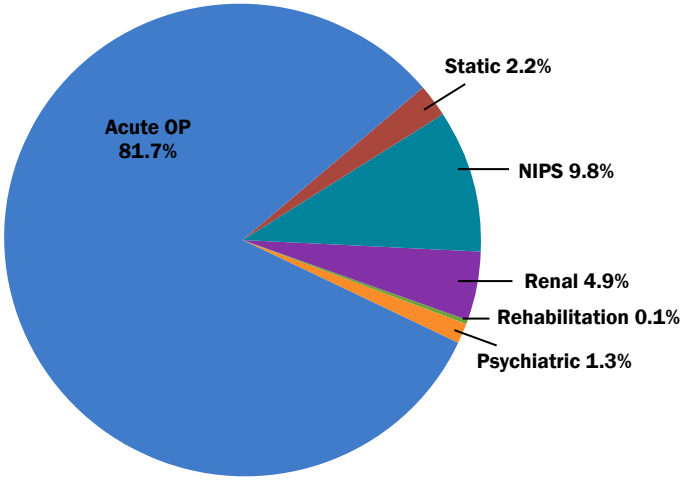
FY 2018 hospital inpatient liability outside of the Department's managed care contracts, including payments for both claims and GRF-funded supplement static payments, totaled $988 billion, a 23.5% drop from the $1.3 billion spent on FFS in 2017. This corresponds with a 37.2% reduction in general acute care admissions for the FFS population. The reductions in utilization and overall payments are directly tied to the movement of individuals into managed care. The entire reduction in inpatient payments is attributable to a reduction in FFS utilization.

Nearly 51% of the $988 billion in FY 2018 hospital inpatient payments were made pursuant to the APR-DRG based system that was implemented July 1, 2014 (62% in FY 2017).

2018 GRF Hospital Inpatient Spending - $988M



2018 GRF Hospital Outpatient Spending - $465 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.

The continued movement to managed care resulted in a 6% decrease in FFS outpatient claims-based reimbursement. Total 2018 spending on institutional claims paid via the EAPG system was $387 million, down from the $413 million in 2017. In 2017, $10.2 million in outpatient payments continued to be paid through monthly supplemental static payments.

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 (NIPS), while supplemental static payments accounted for only 2.2% of outpatient payments compared to 32.8% of inpatient payments.

Disproportionate Share Hospitals

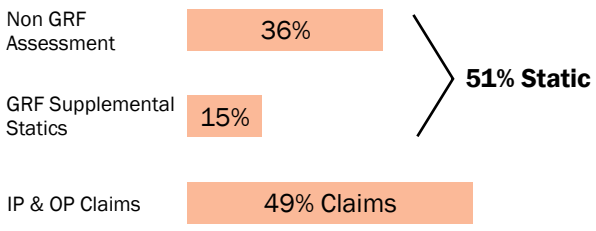
Federal law requires hospitals that serve a disproportionate number of low-income patients with special needs be given an appropriate increase in their inpatient rate or payment amount. Additionally, states are federally mandated to provide the increased payment to any hospital whose Medicaid inpatient 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 2018, HFS expended the entirety of its federal Disproportionate Share Hospital (DSH) allotment of $241.7 million, which equated to about $476.3 million in total spending including state matching funds.

The following numbers of hospitals qualified for DSH in rate year 2018: 79 private (non-governmental) hospitals, including 9 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.

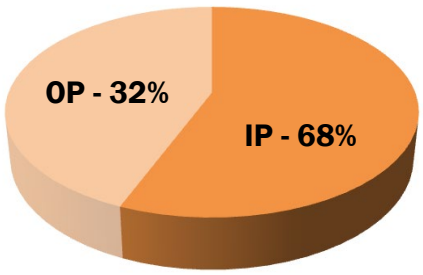
Non-GRF Funded Hospital Payments

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 $2.3 billion in payments are made to the hospitals through both FFS payments and managed care capitation rates.

Total Hospital Payments
Claims vs Static



FY 2018 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 2018, non-certification of medically unnecessary services resulted in direct cost savings of $10.73 million for HFS.

CHAPTER 6

PHARMACY SERVICES

PHARMACY SERVICES

Covered Drugs and Utilization Management

FFS

In accordance with federal Medicaid law, coverage of prescription and certain over-the-counter drugs is limited to products made by companies that have executed rebate agreements with the Centers for Medicare and Medicaid Services (CMS). This en-compasses the vast majority of pharmaceutical manufacturers, and substantially all drugs.

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, 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.

Managed Care

The Department requires managed care organizations (MCOs) to cover only drugs made by manufacturers who participate in the federal Medicaid drug rebate program. The MCOs may determine their own utilization controls, including steps therapy and prior authorization, unless otherwise prohibited under the contract (e.g. the MCOs must utilize the Department's step therapy and prior authorization requirements for family-planning drugs and devices pursuant to the Department's PDL and certain contractual requirements), or State law, to ensure appropriate utilization.

Preferred Drug List/Supplemental Rebate Program

FFS

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 Fiscal Year (FY) 2018, the Department collected approximately $20 million in State supplemental rebates from drug manufacturers. In addition to supplemental drug rebates, the Department collected $7.7 million in rebates on blood glucose testing equipment and supplies.

Managed Care
Each MCO was contractually required to submit its pharmacy formulary for approval by the Department. The MCO is required to provide coverage of drugs in all classes of drugs for which the Department's FFS program provides coverage. The MCO can only cover drugs made by manufacturers who partipate in the federal Medicaid drug rebate program, which applies to both prescription and over-the-counter drugs.

PHARMACY BENEFIT MANAGEMENT SYSTEM (PBMS)

The Department's upgraded PBMS claims processing system was implemented in March of 2017 as part of the third phase of the IMPACT initiative. The new PBMS is a state-of-the-art, real time point of sale claims adjudication system. It enhances the Department's Pharmacy Program by providing improved functionality that was not available in the legacy claims processing system. The new system contains the following functionality:

- Expanded provider portal that contains improved prior authorization request functionality, including the ability to search for prior authorization status as well as claim submission functionality;
- Enhanced prior approval review process that uses diagnosis and other information collected from pharmacy and medical claims data to systematically approve select drugs in defined circumstances;
- Enhanced third party liability claims processing functionality, reducing the need for pharmacies to request third party liability overrides, and maximizing savings on drugs billed for participants who have their party coverage;
- Enhanced override capabilities eliminating the need for most paper claims;
- Enhanced functionality and provider messaging;
- Improved Payor Sheet format; and
- Enhanced claims processing functionality.

The PBMS also processes encounter pharmacy claims submitted by the MCOs.

Reimbursement Methodology

FFS
During FY 2018, the reimbursement rate for single-source medications (brand name) was the lesser of Wholesale Acquisition Cost (WAC) or State Maximum Allowable Cost (SMAC), plus a dispensing fee of $2.40. Multi-source medications (generics) were reimbursed at the lesser of 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 the calculated allowable, or the pharmacy's usual and customary charge. Generic prescriptions comprised 87% of drug utilization, but respresented only 13% of the Department's drug spend. Under the PBMS contract the vendor develops and maintains 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**.

Narcotics Management Program

FFS

The Department has constructed a multi-pronged approach to identify and manage members who are at risk for abuse or misuse of narcotics, while, at the same time, allowing adequate medication supply to members who have a clinical need for narcotic pain control.

Limited Preferred Narcotics – In consultation with our Drugs and Therapeutics Committee, the Department has made a limited number of narcotics available without prior approval. Requiring prior approval allows additional controls to be employed, and to ensure appropriate therapy is being prescribed.

Pain Management Program – The Department's pain management narcotic review program identifies members who are receiving inappropriate narcotic pain medications for chronic pain. This program is designed to assess a patient's current pain management plan and ensure that it is in line with national guidelines.

Quantity Limits/Duplicate Edits – The Department has implemented more restrictive quantity limits on narcotic medications. If a prescription exceeds these limits, a prior approval is required. The Department also reviews the members' drug profile for duplicate therapy and discusses their findings with the members' prescribing physician to resolve those occurrences.

Narcotic Edit – The Department's Narcotic Edit controls access to any controlled pain medication for members with a clinical profile that indicates the member's utilization needs should be managed closely. All prior authorization requests for members with such a clinical profile result in a comprehensive review of the member's Medicaid prescription history, as well those prescriptions that are reported through the Illinois Prescription Monitoring Program.

MANAGED CARE

The MCOs must have an enrollee restriction program in place, in which, at a minimum, the MCO must restrict an enrollee for a reasonable period to a designated PCP or Provider of pharmacy services when: (1) the Department indicates the enrollee was included in the Department's Recipient Restriction Program pursuant to 89 Ill. Admin. Code 120.80 prior to enrollment with Contractor; or (2) the MCO determines that the enrollee is over-utilizing covered services. The MCOs criteria for such determination, and the conditions of the restriction, must meet the standards of 42 CFR §431.54(e)

In addition, the MCO must have a drug utilization review program which shall include processes, procedures, and coverage criteria to include a prospective review process for all drugs prior to dispensing, all non-formulary drug requests, and a retrospective DUR process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. The MCO is required to re-

port prospective and retrospective DUR activities to the Department annually and assist in data collection and reporting to the Department of data necessary to complete the Federal CMS DUR annual report.

Specialty Drug Use

FFS
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.

Managed Care
The MCOs may determine their own utilization controls, including step therapy and prior authorization, unless otherwise prohibited under the contract, or State law, to ensure appropriate utilization. The Department reviews the MCO's utilization controls via various quality assurance reports and the drug utilization review program. Each MCO is required to report prospective and retrospective DUR activities to the Department annually, and assist in data collection and reporting to ensure completion of the Federal CMS DUR annual report.

Four Prescription Policy

FFS
The Four Prescription Policy requires that participants obtain prior approval for prescriptions after they have filled four (4) 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, antipsychotic medications, and anti-rejection medications. 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**.

Managed Care
The MCOs control pharmacy utilization through their utilization management programs which are monitored by the Department through the DUR reports and quality assurance reports submitted by the MCOs.

Hemophilia Care Management Program

FFS

FFS

Through the Department's Hemophilia Care Management Program, quality and utilization control initiatives for patients with hemophilia who are 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 appropriate utilization. Further information can be found on the Department's website at **https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/Hemo.aspx**.

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. The managed care organization (MCO) must follow specific contractual guidelines for maternal and child health promotion such as family planning and reproductive health, including ensuring that national recognized standards of care and guidelines for sexual and reproductive health are followed. More information on the programs offered by HFS and HFS requirements for MCOs can be found at: **https://www.illinois.gov/hfs/MedicalClients/MaternalandChildHealth/Pages/default.aspx** and **https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/default.aspx**.

The births 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**.

MENTAL HEALTH SERVICES

The Illinois behavioral health system continues to be heavily reliant on institutional care rather than community-based care. A significant portion of Illinois's Medicaid behavioral health spend continues to support inpatient or residential care at a percentage that significantly exceeds the national average. This stands in sharp contrast to utilization of the lower cost community-based care, which is less than half of the national average. The over-reliance on institutional based treatment has significant implications for individuals requiring behavioral health care, as they may encounter additional stressors due to removal from their communities to receive treatment in more restrictive institutional settings.

Illinois is undertaking a significant transformation effort to rebalance where behavioral members receive care, focusing efforts on integrating behavioral and physical health services. This effort emphasizes community-based care through the State's 1115 waiver initiatives and the Integrated Health Home (IHH) model. In FY 2018, the Department secured federal approval to move forward with these initiatives and began the process of implementation. In addition, the Department finalized the development of a standardized Integrated Assessment and Treatment Plan (IATP), the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM-CANS). The IM-CANS will assist in improving behavioral health outcomes for members by creating standardization, continuity and consistency in identifying treatment needs as well as member's strengths that can be utilized throughout service delivery.

Managed Care Organizations (MCOs) have been key partners in this transformation. The MCO contracts have quality assurance requirements for the provision of mental health services for adults and children,

and contractual requirements related to the mental health delivery system, such as qualifications for mental health professionals, and detailed children's mental health service requirements.

Mobile Crisis Response Services

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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.

Since July 1, 2004, the SASS program has operated as a single, state-wide 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 for children and youth in the fee-for-service delivery system. 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 FY 2018, the CARES Line received 117,133 calls, of which 111,623 were due to a crisis. Following the crisis event, SASS crisis workers provide crisis intervention services and assist in determining the clinically appropriate level of care for the youth – such as referrals to community-based services, providing case management and treatment services, or, when appropriate, facilitating inpatient psychiatric hospitalization.

In FY 2018, there were 16,523 unique children/youth who experienced one (1) or more crisis events in FFS.

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 has also evolved. Many of the children and youth traditionally serviced by the SASS program are now being served by Mobile Crisis Response (MCR) programs, which are 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. The Departments actively work with HFS-contracted managed care entities to ensure coordination and continuity across the crisis response systems.

In FY 2018, the managed care system responded to 16,453 unique children/youth in crisis.

Psychiatric Consultation Phone Line — Illinois DocAssist

The Illinois DocAssist Program (DocAssist) is a Statewide psychiatric consultation and training service for primary care providers (PCP) or practitioners serving Medicaid enrolled children and youth under age 21 in the fee-for-service and managed care delivery systems. 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. Doc Assist provides consultation services to assist front-line primary care practitioners meet the need for early intervention for children an youth. In addition to providing direct phone consultation, Doc Assist Supports HFS providers by offering targeted training and

educational seminars on common child and adolescent behavioral health issues and makes resources available through its website: **Illinois DocAssist**.

Individualized Care Grant (ICG)

Public Act 99-0479 (20 ILCS 1705/7.1) required the transition of what was historically known as the Individual Care Grant (ICG) program from the Illinois Department of Human Services – Division of Mental Health (DHS-DMH) to the Department. In FY 2017, HFS assumed administrative control of the ICG program, spending the year gaining foundational knowledge and seeking ways improve the program to be consistent with the State's efforts related to the behavioral health transformation. In FY 2018, HFS revamped the program to better reflect the Department's behavioral health policies through the promulgation of Title 89 Illinois Administrative Code, Part 139 (Rule 139) in May 2018, transitioning what had been the ICG program to the Family Support Program (FSP). Rule 139 redefined eligibility criteria for entering the program, making services more readily available to a wider array of Illinois youth. Rule 139 also introduced utilization management components to ensure those enrolled in FSP are receiving the clinically appropriate level of care from community-based FSP providers, or from a residential treatment facility suited to best address their needs. In FY18, 422 youth were served through FSP.

Specialized Family Support Program (SFSP)

The Specialized Family Support Program (SFSP) was implemented pursuant to the Custody Relinquishment Prevention Act **20 ILCS 540/**, effective January 1, 2015. It is a collaborative effort between HFS and the Departments of Children and Family Services DCFS), Human Services (DHS) Juvenile Justice (DJJ), Public Health (DPH) and the Illinois State Board of Education (ISBE). SFSP is designed to identify youth at risk of custody relinquishment and their behavioral health needs and link them and their families to appropriate clinical services to support family reunification.

SFSP is an expansion of the Illinois behavioral health crisis response system for youth utilizing existing resources found in the Screening, Assessment and Support Services (SASS), Comprehensive Community-Based Youth Services (CCBYS) and Intensive Placement Stabilization (IPS) programs.

Through leveraging these existing state resources, altering key program policies to accommodate the specialized needs of this population, and providing access to community stabilization services, SFSP is now actively assessing and linking youth at risk of custody relinquishment and their families to services through the most appropriate State agency. SFSP has been implemented consistent with the Department's efforts related to the behavioral health transformation, including the implementation of the managed care delivery system. In fy18, 61 youth were served through SFSP.

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

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The FFS HFS Dental program is administered by DentaQuest of Illinois, LLC (DentaQuest). HFS, through DentaQuest, offers many dental services to children and adults. DentaQuest is responsible for dental claims adjudication and payment, prior approval of services, ongoing reporting to the Department and quality assurance monitoring. 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

Managed Care

The MCOs must provide, at a minimum, the dental services covered in the fee-for-service program. Some MCOs provide dental services not covered by the FFS program as a value added service not reimbursed through the capitation rate paid by the Department to the MCOs. See the Illinois Client Enrollment Services website for more information regarding the scope of dental services offered by the MCOs at **https://enrollhfs.illinois.gov/**.

FY 2018 Dental Payments

	Number of Individuals	Dental Services	Payments
Individuals under 21	227,837	1.5 million	$50.5 million
Individuals over 21	107,702	0.6 million	$23.3 million
Total	**335,343**	**2.1 million**	**$73.8 million**

Total unique individuals (335,343) does not equal the sum of the two age groups (0-20 or 21 and over) as some individuals reached age 21 in FY18.

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 in both the FFS and managed care delivery system. 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 251,000 children received direct medical services through the school-based program during FY 2018. LEAs were reimbursed over $108 million for their costs to provide these services, as well as about $43.8 million for care coordination costs and 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 2018, the OIG successfully implemented legislative and enforcement initiatives that resulted in $191.1 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 2018

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 hospital services

Emergency medical services 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 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:

Case management services

Certified Registered Nurse Anesthetist

Chiropractic services

Clinic services

Clinical Nurse Specialist

Dental services, including dentures

Diagnostic, screening and preventive services

Durable medical equipment and supplies

Eyeglasses

Hospice services

Inpatient psychiatric services (IMD) for individuals under 21 years of age

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

Licensed Clinical Social Worker services

Licensed Psychologist services

Nursing facility services for individuals under 21 years of age

Occupational therapy services

Optometry services

Physical therapy services

Podiatric services

Prescribed drugs

Prosthetic devices

Rehabilitative services (Medicaid Rehab Option/School-Based Health)

TB related services

Speech, hearing and language disorder services

TABLE II

HFS MEDICAL ASSISTANCE PROGRAM Expenditures Against Appropriations - FY 2016 - 2018 *Dollars in Thousands*						
	FY 2016 Expenditures	**Percent**	**FY 2017 Expenditures**	**Percent**	**FY 2018 Expenditures**	**Percent**
Total[1,2]	**$12,259,335.6**	**100.0%**	**$13,180,409.9**	**100.0%**	**$14,038,924.6**	**100.0%**
Hospitals	**1,951,989.4**	**15.9%**	**1,888,213.7**	**14.3%**	**1,904,320.0**	**13.6%**
Long Term Care[3]	**1,436,222.5**	**11.7%**	**1,063,433.3**	**8.1%**	**980,484.5**	**7.0%**
Practitioners	**595,776.8**	**4.9%**	**506,770.7**	**3.8%**	**488,985.7**	**3.5%**
Physicians	456,333.7	3.7%	393,237.1	3. 0%	395,040.8	2.8%
Dentists	116,545.6	1.0%	94,902.6	0.7%	76,978.2	0.5%
Optometrists	20,242.8	0.2%	16,170.5	0. 1%	14,308.0	0. 1%
Podiatrists	2,553.3	0.0%	2,381.6	0.0%	2,600.4	0.0%
Chiropractors	101.4	0.0%	78.9	0.0%	58.3	0.0%
Drug	**1,002,102.3**	**8.2%**	**1,205,783.4**	**9.1%**	**1,111,615.3**	**7.9%**
Other Medical	**1,065,740.0**	**8.7%**	**1,150,664.7**	**8.7%**	**1,090,678.8**	**7.8%**
Laboratories	34,970.4	0.3%	26,699.4	0. 2%	26,218.7	0. 2%
Transportation	49,423.5	0.4%	44,414.9	0. 3%	41,297.5	0. 3%
SMIB/HIB/ Expansion[4]	436,332.9	3.6%	496,224.2	3. 8%	524,658.2	3. 7%
Home Health Care/DSCC	126,815.9	1.0%	128,672.4	1.0%	113,391.6	0.8%
Appliances	47,456.2	0.4%	48,481.9	0.4%	45,298.5	0.3%
Other Related[5]	154,732.8	1.3%	195.218.4	1.5 %	152,455.8	1.1 %
Community Health Centers	143,577.9	1.2%	137,226.0	1.0%	128,650.2	0.9%
Hospice Care	72,403.4	0.6%	73,727.5	0.6%	58,708.3	0.4%
MCOs	**6,207,504.6**	**50.6%**	**7,365,544.1**	**55.9%**	**8,462,840.3**	**60.3%**
Children's Health Rebate	**0.0**	**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 2017 administrative spending from the Health care 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 2017.

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.