ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, HFS Director

FY 2019
ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

April 1, 2020

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 or HFS), I am pleased to present the Fiscal Year 2019 Annual Report of the Department's medical assistance programs, most commonly known as Medicaid, CHIP, and All Kids. Every day, 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 2019, the Department accomplished a range of goals, and we continue to make progress. Major accomplishments include implementing provider rate increases and program improvements from 2019 Medicaid Omnibus Bill, clearing nearly 750,000 billing adjustments with MCO and provider partners, establishing the Managed Care Provider Assessment, significantly reducing the backlog of applications and renewals for Medical Assistance, putting in place new rules and rates for gender affirming services and supports, and restoring the Vaccines for Children Program in tandem with the Illinois Department of Public Health.

This report provides details on specific initiatives, participant numbers, and provider reimbursement for Fiscal Year 2019 and, in some instances, the two previous years for purpose of comparisons and statutory requirements.

We are committed to engaging with all stakeholders to continually improve the way we help those we serve. 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 Healthcare and Family Services (Department or HFS) 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 2017	FY 2018	FY 2019
Children	1,462,872	1,432,135	1,338,234
Adults with Disabilities	246,813	264,840	254,741
Other Adults	592,850	552,597	498,238
Seniors	207,590	216,942	217,220
ACA Newly Eligible Adults	631,693	623,891	570,551
All Comprehensive	3,141,818	3,090,405	2,923,984
All Partial Benefits	17,187	33,175	43,213
Grand Total All Enrollees	**3,159,553**	**3,123,580**	**2,967,197**

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 age 19 with family income at or below 147% of the Federal Poverty Limit (FPL) ($3,210 per month for family of four (4)). **Presumptive Eligibility** - Yes **Benefit** - Comprehensive **Cost Sharing** - No

All Kids Share
Eligibility - Children up to age 19 with family income above 147% and at or below 157% FPL (between $3,211 and $3,428 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 age 19 with family income above 157% and at or below 209% FPL (between $3,429 and $4,563 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 age 19 with family income above 209% and at or below 318% FPL (between $4,564 and $6,943 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 $4,651 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 ($3,013 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 $1,983 for a couple). **Presumptive Eligibility** - No
Benefit - Comprehensive **Cost Sharing** - No

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 ($1,063 for a single person and $1,437 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** - No

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** - No

Health Benefits for Workers with Disabilities (HBWD)

Eligibility - Employed persons with disabilities with earnings up to 350% FPL ($3,722 per month for an individual, $5,028 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 - I Individuals under age 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** - No

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 $7,730 for a single person and $11,600 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

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

PROGRAM COSTS

During FY 2019, 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).

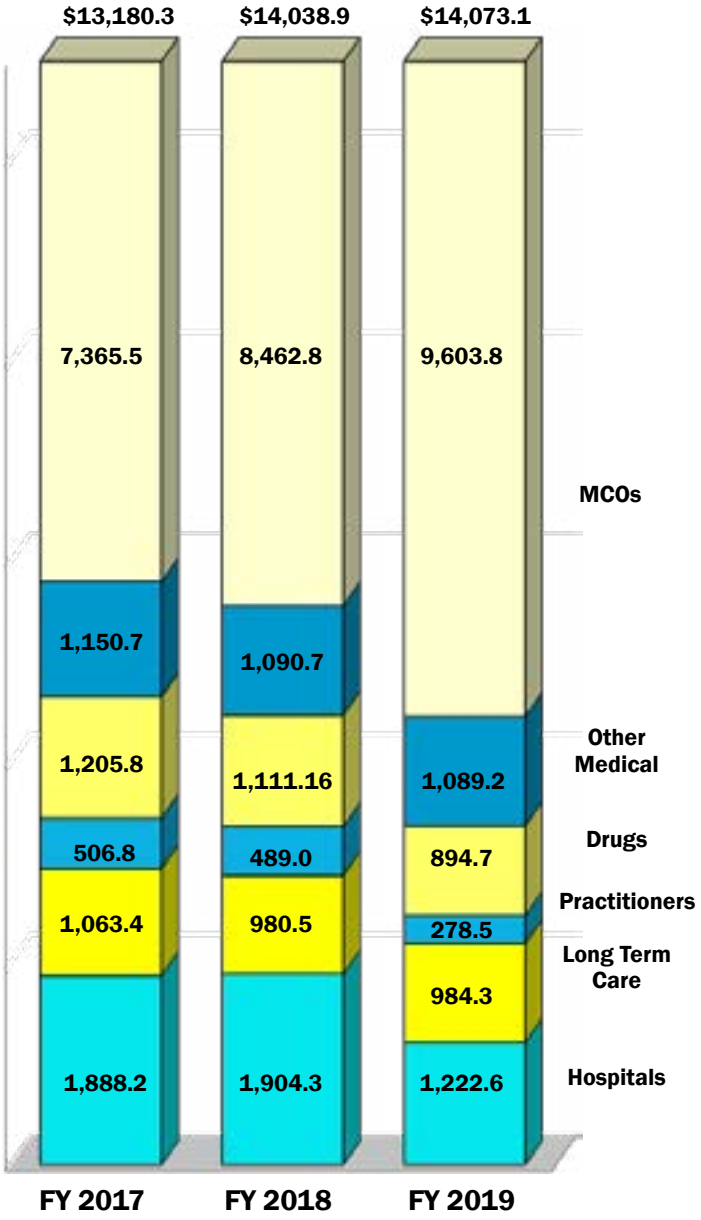
Medical Programs Spending

FY 2017 - 2019
Dollars in Millions

2017 - In FY 2017, MLTSS was introduced resulting in the transfer of prior FFS liability from other agency budgets. Other liability pressures include continued Affordable Care Act (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 Managed Care Organization (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.

2019 - A new hospital assessment began July 2018, which included money for hospital rate increases. The FY19 Budget Implementation Bill included provider rate adjustments along with programmatic expansions/adjustments.



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 2017-2019.

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

This administration recognizes that health care is a right for all, not a privilege. The Department has been 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 so that we can serve our members efficiently and effectively.

In the summer of 2019, the Governor enacted a Medicaid overhaul (SB 1321) to increase the timeliness of applications, redeterminations and payments to providers and decrease the number of Medicaid claims denials, as well as to expand transparency throughout the program. Aggressive action before and afterward has been undertaken through a broad range of strategies to bring down the unacceptable Medicaid backlog that built up over a number of years under previous administrations.

Managed Care

In addition to addressing backlogs, among the areas of managed care enhancements and reforms addressed by SB 1321 are: Reimbursement for stays beyond medical necessity, expedited payments, timely payment interest penalties, dispute resolution process, claims rejection/denial management, timely filing extension for eligibility errors, provider effective dates, provider directory updates, operational standardization, medical loss ratios and value-based payment models.

SB 1321 passed with bipartisan support and forms a central part of the Department's wide-ranging improvements and enhancements of Medicaid managed care.

See **Care Coordination** for more information.

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

As of January 1, 2020, approximately 77% 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.

Current Managed Care Programs

The Department currently operationalizes two care coordination programs: the HealthChoice Illinois Program and the Medicare Medicaid Alignment Initiative (MMAI) Program.

The HealthChoice Illinois Program which began January 1, 2018 is a statewide, mandatory program for most Medicaid recipients who have full Medicaid benefits. HFS holds contracts with 6 MCOs to serve the HealthChoice Illinois population.

The program began January 1, 2018 but only included specific populations. In July 2019, the following populations were added to the HealthChoice Illinois program: individuals who receive managed long term service and supports. Those individuals include beneficiaries receiving full Medicare (both Part A and Part B) and Medicaid benefits, who are not enrolled in the Medicare-Medicaid Alignment Initiative (MMAI) program, and reside in a nursing facility or are in the following **Home and Community-Based Services (HCBS) waivers**: Supportive Living Program, Persons with Disabilities, Persons with HIV or AIDS, Persons with Brain Injury, and Persons who are Elderly.

Medicare is the primary payer for dual eligible beneficiaries, including HealthChoice Illinois MLTSS enrollees; MLTSS covers some long term supports and services, along with some mental health and transportation services All HealthChoice Illinois MLTSS enrollees who live in a county with a **Medicare-Medicaid Alignment Initiative (MMAI)** health plan may choose to enroll in MMAI instead of MLTSS at any time. WellCare/Harmony Health Plan acquired Cadan Enterprises/Meridian Health Plan of Illinois during FY 19 keeping Meridian's name. Beginning January 1, 2019 Meridian began providing services to previous Harmony Health Plan membership excluding the membership who chose another health plan.

Medicare/Medicaid Alignment Initiative (MMAI)
The Medicare/Medicaid Alignment Initiative is a three-way partnership between HFS, Federal Centers for Medicare and Medicaid Services (CMS) and health plans. MMAI is an effort to reform the way care is delivered to clients who are eligible for Medicare and Medicaid services (dual eligible) by providing coordinated care. In FY 2019, MMAI was operational in the Greater Chicago Region and parts of the Central Illinois Region. There are 6 MCOs providing services under MMAI.

MCOs providing services under MMAI are responsible for covering all Medicare and Medicaid services,including Long Term Services and Supports. Enrollees can opt out of MMAI at any time, as well as re-enroll at any time; however, enrollees that receive Long Term Services and Supports and request to opt out of MMAI are required to participate in the HealthChoice Illinois program. The HealthChoice Illinois health plans cover a limited service package for Long Term Services and Supports. All other services will be covered by Medicare and Medicaid fee for service.

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.

Provider Complaint Portal

Providers continue to learn to operate in a moderately 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/ManagedCare Complaints.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 will revamp the provider portal in calendar year 2020. The new portal will enable the department to 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 2020.

Comprehensive Billing Guide for Providers

The Medicaid health plans have historically referred providers to follow HFS' fee for service billing guidelines to submit claims. The health plans have their own nuances that are not captured under HFS billing guidelines. With the cooperation of the Department, the health plans, through collaboration under the Illinois Association of Medicaid Health Plans (IAMHP), are publishing billing guidelines for most provider types under HFS. The goal is to standardize the claims and billing-related policies and procedures, thus reducing denials of provider claims and improving provider relations. Work started on the billing manual in FY 18 and continues into FY 19. Sections of the manual that have been approved for publication can be found here: **https://iamhp.net/providers**

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.

P4P measures are 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% may 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, Affordable Care Act (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 2019 Enrollment**
	Blue Cross/Blue Shield of Illinois	390,897
	CountyCare Health Plan	317,846
	IlliniCare Health Plan Inc.	343,104
	Meridian Health Plan Inc.	790,741
	Molina Healthcare of Illinois Inc,	214,293
	NextLevel Health	46,079
	Total Health Plan Enrollment	**2,102,960**

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 2019 Enrollment**
	Aetna Better Health Inc.	7,175
	Blue Cross/Blue Shield of Illinois	18,142
	Humana-Health Plan	7,842
	IlliniCare Health Plan Inc.	7,238
	Meridian Health Plan Inc.	7,438
	Molina Healthcare of Illinois	6,180
	Total Health Plan Enrollment	**54,015**

Total MCO Program	**Health Plans**	**June 2019 Enrollment**
MMAI	Aetna Better Health Inc.	7,175
HealthChoice Illinois, MMAI	Blue Cross/Blue Shield of Illinois	409,039
HealthChoice Illinois	CountryCare Health Plan	317,846
MMAI	Humana Health Plan	7,842
HealthChoice Illinois, MMAI	IlliniCare Health Plan Inc.	350,342
HealthChoice Illinois, MMAI	Meridian Health Plan Inc.	798,179
HealthChoice Illinois, MMAI	Molina Healthcare of Illinois Inc.	220,473
HealthCHoice Illinois	NextLevel Health	46,079
	Total MCO Enrollment	**2,156,975**

Quality Assurance

State Quality Assessment and Performance

Improvement Strategy for Managed Care

HFS developed Partnering for Performance: Making the Choice for Quality as its Medicaid Com- prehensive 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: 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 2019

Specialized Mental Health Rehabilitation Facilities (SMHRFs)

- 24 SMHRFs
- Just under 4,000 beneficiaries served in FY 2019

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

- 220 ICF/IIDs
- Just under 5,000 beneficiaries served in FY 2019

Licensed & Medicaid Certified LTC Beds
Fiscal Year 2019 Actual

Level of Care	Medicaid Certified Beds[1]	Licensed Beds[2]
Skilled Care	71,375	80,957
Specialized Mental Health Rehabilitation Facilities (SMHRFs)	0	4,332
Intermediate Care (ICF)	9,317	9,624
Intermediate Care for Individuals with Intellectual Disabilities	4,326	4,326
Skilled Care for Individuals with Intellectual Disabilities	932	932
Total	**85,950**	**100,197**

[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 2017 - 2019

Long Term Care - Total				
	FY 2017	FY 2018	FY 2019	% Change FY 2017 to FY 2019
Total HFS Liability[1] ($ Millions)	$1,164.92	$1,033.81	$1,132.45	-2.79%
Total Patient Days (Millions)	10.73	8.82	9.56	-10.90%
Weighted Average Rate[2] Per-Diem	$108.57	$117.26	$118.40	9.11%
Average Payment (Charge) Per-Diem[3]	$141.05	$143.59	$143.72	1.89%

[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 2019 is $156.42. 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
2018	$181.5	$16.9
2019	$200	$17.6
2020	$168.7	$18.3
2021	$179.8	$18.6

**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, providing billing assistance and information to providers, resolving billing discrepancies, and coordinating admissions information entry with the Department of Human Services (DHS). 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 61 facilities in FY 2019.
- 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 Three (3) NFs.

Certification/Decertification of Long Term Care Facilities

During FY 2019 eight (8) NFs; one (1) SMHRF and nine(9) ICF/IIDs voluntarily closed. Seven (7) NFs closed due to financial hardship and one (1) closed due to unknown reason(s). One (1) SMHRF closed due to financial hardship. Seven (7) ICF/IID converted to a Community Integrated Living Arrangement (CILA); one (1) closed due to financial hardship and one (1) due to other. All residents were relocated to appropriate settings. Three (3) new NFs; no (0) SMHRF and no (0) new ICF/IIDs were enrolled in the medical assistance program during this same period.

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 150,296 people in state fiscal year 2019. 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.

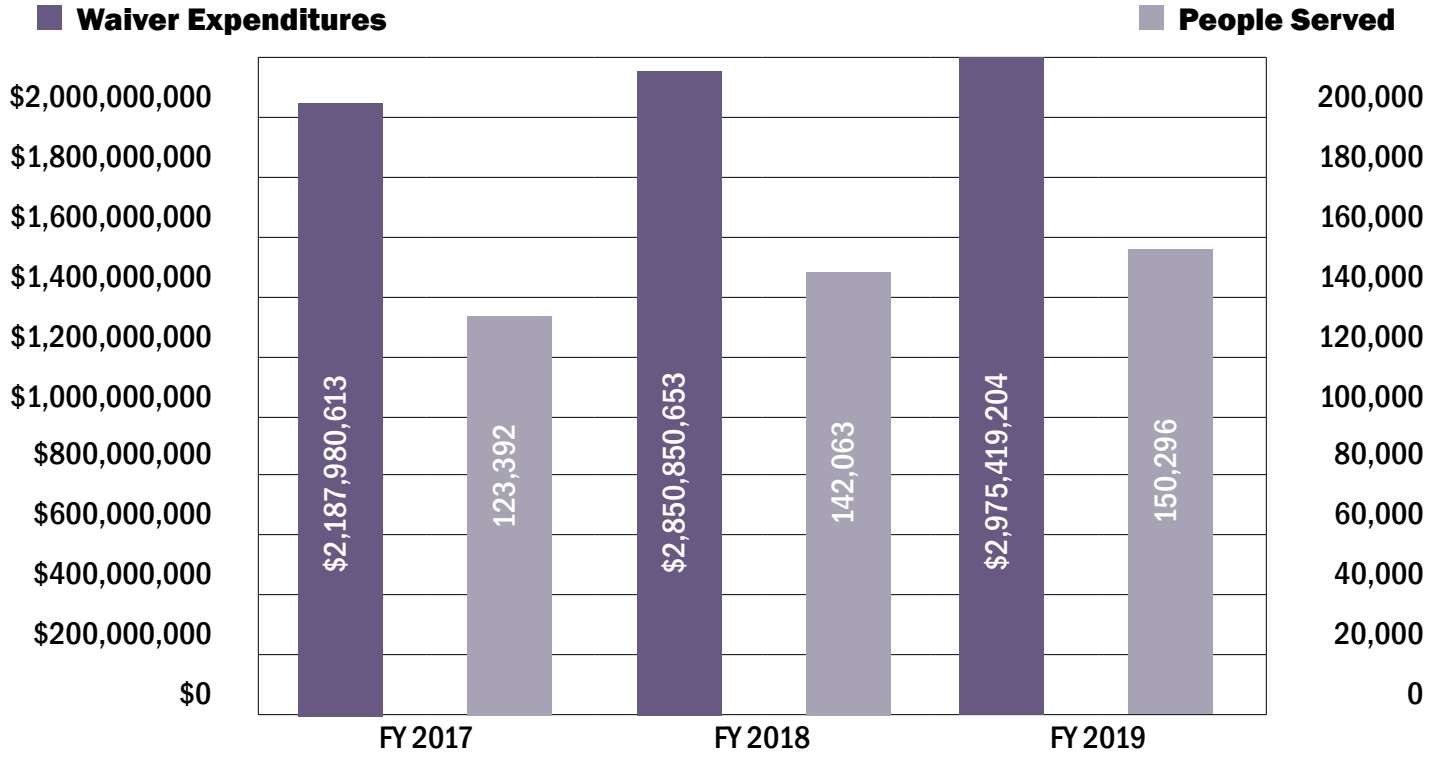
All but the supportive living program waiver are operated by non-HFS state agencies through interagency agreements. Each waiver is designed for individuals with similar needs and offers a different set of services. The waivers and the operating agencies are:

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, 2022. 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/TransitionPlan.aspx#Subhead6**.

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, 2018 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
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%
2019	$3,071,946,212	$1,585,848,577	51.62%

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.

CHAPTER 5

HOSPITAL SERVICES

HOSPITAL PROVIDER REIMBURSEMENT

Hospitals are reimbursed in several ways, including:

- Inpatient Claims
- Outpatient Claims
- Disproportionate Share Hospital Payments
- Hospital Assessment-Funded Supplemental Payments
- Payments from Managed Care Organizations

Please Note: The payment and utilization data presented in this section and the outpatient section that follows was previously limited to those individuals covered under fee for service reimbursement and did not include those covered under a Medicaid Managed Care plan. This is the first year managed care encounter data has been included for the FY18 and FY19 narrative.

Also, these sections do not include data from the large government owned or university owned hospitals that provide a portion of the state's share of reimbursement nor does it include hospital payments that are partially funded through hospital assessments, unless otherwise noted.

259 cost reporting hospitals participated in the Illinois Medicaid program in FY 2019

Inpatient Hospital Services - General Revenue Fund (GRF)

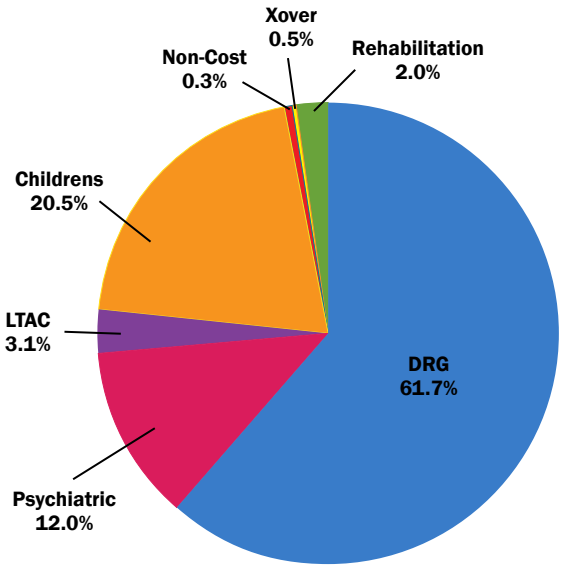
Inpatient hospital claims consist of acuity based groupings - called All Patient Refined Diagnosis Related Groups (APR-DRG) with several specialized claims based add-ons, including disproportionate share, safety-net, psychiatric, Medicaid Percentage Adjustment and Medicaid High Volume Adjustment. Some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

Total hospital inpatient liability, including payments for both FFS and Encounter claims totaled $2.400 billion, relatively flat from the $2.406 billion spent in 2018. This corresponds with a 7 % decrease in total inpatient admissions. The variance in the decreases in liability and admissions is due to the increase in inpatient hospital rates that took effect July 1, 2018.

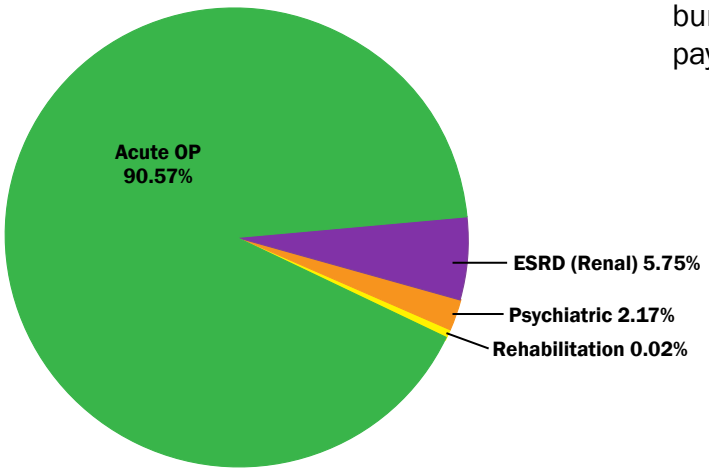
As shown in the graph on the following page, nearly 61.7% of the $2.4 billion in state fiscal year 2019 hospital inpatient payments were made pursuant to the APR-DRG based system that was implemented July 1, 2014. That is up from 59.8% in fiscal year 2018. Some services continue to be paid on a per diem basis, excluded from the APR-DRG, including psychiatric and rehabilitation, as well as services provided by long term acute care hospitals and non-cost reporting hospitals.

Nearly 61.7% of the $2.4 billion in FY 2019 hospital inpatient payments were made pursuant to the APR-DRG based system that was implemented July 1, 2014 (59.8% in FY 2018).

2019 GRF Hospital Inpatient Spending - $2.4 Billion



2019 GRF Funded Hospital Outpatient Spending - $1.3 Billion



Ambulatory Care Services

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

Total 2019 spending on institutional claims paid via the EAPG system was $1.3 billion, up from the $1.1 billion in 2018. Total 2019 outpatient services were down 4% from 2018. The variance in the decreases in liability and admissions is due to the increase in outpatient hospital rates that took effect July 1, 2018.

Unlike inpatient spending, most hospital outpatient spending is for direct patient claims reimbursed through the EAPG, as well as some renal payment.

Disproportionate Share Hospitals

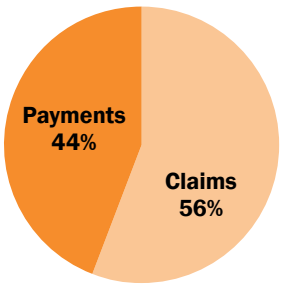
Federal law requires hospitals that serve a disproportionate number of low-income patients with special needs be given an appropriate increase in their inpatient rate or payment amount. Additionally, states are federally mandated to provide the increased payment to any hospital whose Medicaid inpatient 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 2019, HFS expended the entirety of its federal Disproportionate Share Hospital (DSH) allotment of $246.7 million, which equated to about $490.4 million in total spending including state matching funds.

The following numbers of hospitals qualified for DSH in rate year 2019: 75 private (non-governmental) hospitals, including 16 which received DSH payments because they were within the federal guidelines set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1993; two (2) 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.

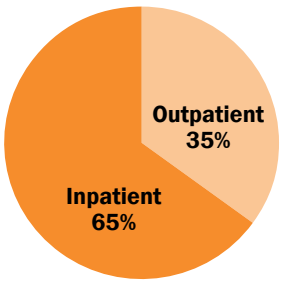
Non-GRF Funded Hospital Payments

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 GRF, these payments utilize funding garnered through both an inpatient and outpatient assessment on Illinois hospitals. In total, nearly $2.9B in payments are made to the hospitals through both FFS payments and managed care capitation rates.

Total Hospital NON-GRF Payments vs Claims



FY 2019 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 encompasses the vast majority of pharmaceutical manufacturers, and substantially all drugs.

The Department 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) 2019, the Department collected approximately $8.3 million in State supplemental rebates from drug manufacturers. In addition to supplemental drug rebates, the Department collected $2.2 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.

Reimbursement Methodology

FFS
During FY 2019, 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 86% of drug utilization, but respresented only 14% 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 report 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 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**.

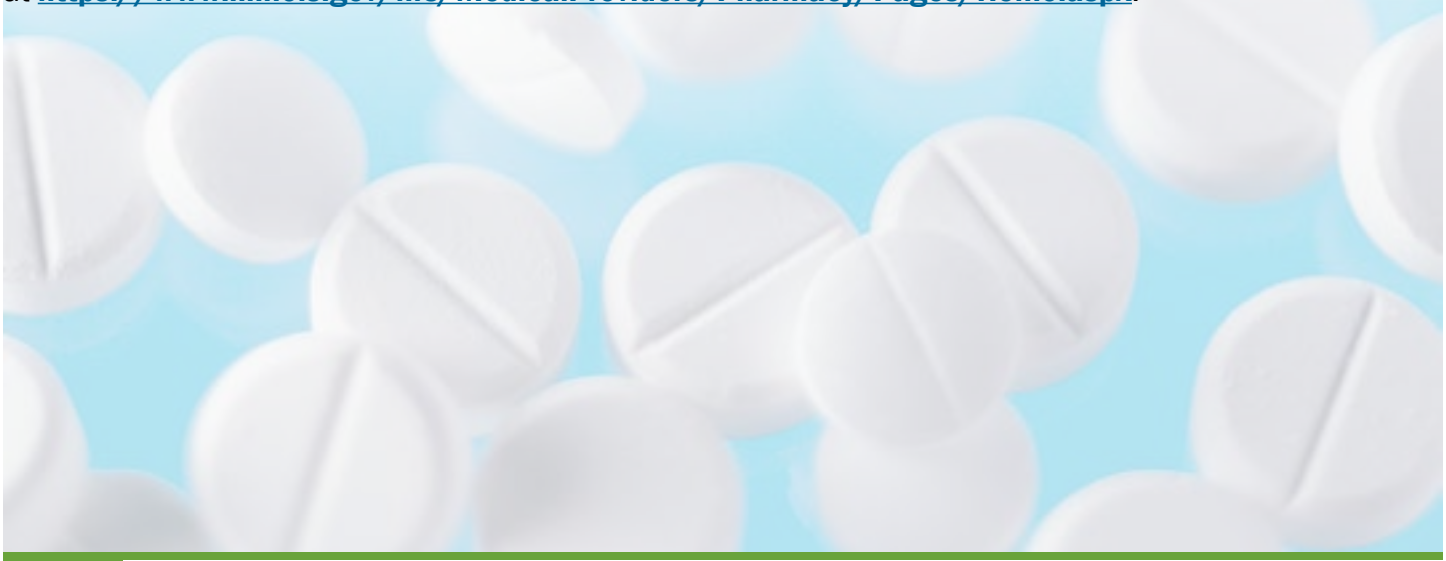
Managed Care

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

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 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 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**. The Department continues to assess maternal/child health outcomes and continues to make improving maternal health and birth outcomes a priority in Illinois.

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 through the Integrated Health Home (IHH) model. The IHH model will create a comprehensive system of care coordination for Medicaid enrolled individuals with chronic conditions. The overall goals of the IHH model include: a person and/or family-centered coordination care delivery models for adults and children with complex physical and behavioral health needs; a flexible care management delivery approach that reflects the diverse needs of members in Illinois and recognizes that member needs change over time; an appropriate balance between IHH flexibility and accountability to enable capabilities and readiness; and the sustainability of care management models for high need adults and children.

The Department launched 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. In FY 2019, approximately 10,000 providers received in-person training on the IM+CANS.

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

FFS

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 2019, the CARES Line received 145,180 calls, of which 139,152 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 2019, there were 12,283 unique children/youth who experienced one (1) or more crisis events in FFS.

In FY 2019, the managed care system responded to 18,829 unique children/ youth in crisis.

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 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.

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 and youth. In addition to providing direct phone consultation, Doc Assist Supports HFS providers by offering targeted training an educational seminars on common child and adolescent behavioral health issues and makes resources available through its website: **Illinois DocAssist**.

Family Support Program

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 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), 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. In FY2019, the Department continued to provide a coordinated system of community-based and residential treatment services that vary in scope and intensity to meet the needs of youth in the program. In FY2019, 526 youth were served through FSP. This is a 25% increase from FY2018.

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 FY 2019, 35 youth were served through SFSP.

INTEGRATED CARE FOR KIDS (InCK) MODEL GRANT

Late in FY2019, the Department partnered with two provider organizations, Ann & Robert H. Lurie Children's Hospital of Chicago and Egyptian Health Department, to apply for the Integrated Care for Kids (InCK) Model grant. The InCK Model is a child-centric service system and state payment model that seeks to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. This federal grant opportunity is a 7-year Model that will be awarded and launched in FY2020.

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

FFS

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 2019 Dental Payments			
	Number of Individuals	Dental Services	Payments
Individuals under 21	128,321	803,873	$25.5 million
Individuals over 21	74,528	391,320	$16.2 million
Total	**202,753**	**1.2 million**	**$41.7 million**

Total unique individuals (202,753) does not equal the sum of the two age groups (0-20 or 21 and over) as some individuals reached age 21 in FY19.

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.

Approximately 241,000 children received direct medical services through the school-based program during FY 2019. LEAs were reimbursed over $119 million for their costs to provide these services, as well as about $43.1 million for care coordination costs and outreach.

REIMBURSING SCHOOL-BASED HEALTH SERVICES

Since 1992, the School- Based Health Services program has actively participated in the Medicaid/education partnership established by the Medicare Catastrophic Coverage Act (Public Law 100-360). This partnership allows Local Education

Agencies (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**.

Centers for Medicare and Medicaid Services (CMS) Substance Use Disorder Treatment Capacity Planning Grant – Illinois SUPPORT Initiative

The Department recently (September 2019) received a $4.5 million grant award from the Center for Medicare and Medicaid Services (CMS) for the Illinois SUPPORT Act: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity Initiative. The Illinois SUPPORT project is an 18-month planning initiative which supports a comprehensive needs assessment and additional activities to develop the state's infrastructure to expand provider capacity to deliver substance use disorder (SUD) treatment and recovery services for Medicaid members with SUD. The goal of the Illinois SUPPORT project will be to increase access to community-based services, including medication-assisted treatment (MAT), for Medicaid members as part of a comprehensive, public health approach to addressing the opioid crisis. To accomplish this goal of improving treatment capacity, the grant will allow HFS to do the following: 1) Conduct data-driven needs assessments for substance use disorder and opioid use disorder (OUD) for Medicaid beneficiaries; 2) Increase training for providers of MAT; 3) Expand technical assistance for prescribers through in-person and web-based platforms; and 4) Improve the accuracy of the MAT Provider Database. In addition, the grant funding will allow HFS to accomplish the following:

- Collect and analyze detailed information on the behavioral health needs, including the substance use treatment and recovery support needs of Medicaid members in Illinois.
- Develop strategies to build the state's infrastructure for increasing capacity and reduce the gaps in Medicaid-covered SUD treatment and recovery services.
- Train new providers and provide technical assistance to new and existing providers to increase provider capacity to service vulnerable areas and to create a support network for providers serving Medicaid members with SUD and OUD.

Upon completion of the 18-month planning phase, HFS will submit a SUPPORT Implementation Grant application to CMS, which would support a 36-month service expansion phase. If Illinois is selected for the implementation phase, CMS will allow for enhanced reimbursement of SUD and OUD services, which will increase access to MAT and other critical recovery supports for Medicaid members in Illinois.

CHAPTER 8

PROGRAM INTEGRITY

PROGRAM INTEGRITY

The Medicaid Inspector General reports directly to the Governor of Illinois and his (OIG) has statutory mandate "to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct." In this capacity the OIG must comply with a variety of responsibilities as follows to ensure program integrity (305 ILCS 5/12-13.1):

- Employee Misconduct Investigations
- Prepayment and post-payment audits of medical providers
- Recovery of overpayments
- Monitoring of various programs including but not limited to:
  - Quality control measurements
  - Investigations of fraud or intentional program violations
  - Actions initiated against contractors, vendors, or medical providers
  - Enforcing sanctions initiated at both state and federal levels
  - Legal Representation on sanctions against medical service providers

The OIG uses a predictive modeling platform: "Dynamic Network Analysis" (DNA) for statistical analysis, executive dashboards, profiling and identifying data outliers for additional research as follows:

- **Long Term Care Asset Discovery Investigations (LTC ADI):** unit is responsible for ensuring that Long Term Care (LTC) residents requesting coverage for LTC services are eligible and in compliance with federal and state regulations before they receive state assistance. The goal of the unit is to ensure that individuals applying for LTC services do not have excess resources or unallowable transfers of the resources which would allow them to pay for their own nursing home care. By preventing improper conduct related to eligibility, the LTC-Asset Discovery Investigations Unit ensures program funds go to qualified applicants who have no other means to pay for their own care.

  Applications are referred to the OIG from the DHS Family community Resource Centers (FCRCs) as a result of meeting specific criteria. LTC-ADI Analysts complete reviews of financial records and applicant information up to five years from the date of the application for benefits. Directives are made and provided back to the FCRC's to allow DHS to send out notices advising the applicants of their eligibility for the program. In Fiscal Year 2019, the LTC-ADI program identified a cost savings of $87,396,673.25 and cost avoidance of $48,990,425.40 for a total savings of $136,387,098.65.

- **Peer Reviews of Providers for Quality of Care:** The Peer Review Unit conducts quality of care reviews and monitors utilization of services rendered to Medicaid recipients from records submitted by a provider/applicant. Quality of care concerns are summarized in the categories of risk of harm, medically unnecessary care or care in excess of needs, and grossly inferior quality of care. Risk of harm is identified when there is a risk to the patient that outweighs the potential benefit of the service. Medically unnecessary care or care in excess of needs is identified when the care provided to the patient is not medically necessary and/or in excess of the patient's needs. Grossly inferior quality of care is identified when "flagrantly bad care" is provided to a patient. Peer Review conducts reviews of physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. Peer review cases can originate from hotline/complaints; referral from the Provider Analysis Unit, Recipient Restriction Unit, Audit Unit or other agencies such as the Illinois Department of Financial Professional Regulation, State Police, or Public Health.

Peer Review cases can also be cases where the provider has been reviewed by the Peer Review Unit previously and quality of care concerns were identified but were not serious enough to terminate the provider. Peer Review Unit will review the provider again to see if the concerns have been rectified. If a provider was terminated, suspended, or withdrew from the Program and submitted his/her enrollment application in IMPACT, a reinstatement case will be created and sent to the Peer Review Unit to conduct a quality of care review. If a potential provider submitted his/her application in IMPACT but had a red flag such as a discipline on their license, an enhanced enrollment case will be created and sent to the Peer Review Unit to conduct a quality of care review.

The Peer Review staff reviewer visit the provider's office to obtain the recipient records or may request the provider send the office records to the Department. A written report documenting the quality of care concerns and the recommendations is subsequently completed by the staff reviewer. Possible recommendations may include case closure with no concerns; case closure with minor deficiencies identified and sending a letter to the provider identifying these minor concerns; or a referral to a consultant for further review of potentially serious concerns. The consultant will review the office records and will submit a written report to the Department identifying quality of care concerns along with a recommendation to the Department. The consultant may recommend that a letter be to be sent to the provider outlining quality of care concerns and recommendations when minor concerns are identified. If the consultant has identified more serious quality of care concerns the Department will request that the provider attend a Medical Quality Review Committee (MQRC) meeting to discuss the care provided and attempt to clarify or discuss the concerns identified with the provider. The MQRC committee will consist of two to three departmental consultants of like specialty. If the provider is board certified, at least one committee member must be board certified in the same branch of medicine. The MQRC makes a recommendation to the Department prior to the conclusion of the meeting after the provider is dismissed. The committee may recommend that the provider be sent a letter identifying concerns that the provider should correct in his/her practice. Possible action against the provider include the following: termination; corporate integrity agreement in lieu of termination; suspension; denial of reinstatement; denial of enrollment; or referral to the Audit Unit if potential compliance issues are suspected. In addition, a referral may be sent to the Department of Public Health and/or the Department of Financial and Professional Regulation for related regulatory actions.

- **Post Payment Audits:** The Bureau of Medicaid Integrity (BMI) conducts program integrity audits on all provider types enrolled in the Illinois Medical Assistance Program. All Medicaid providers are subject to audit. Through these audits the OIG ensures compliance with State and federal law and Department Policy. The OIG uses a number of factors in determining the selection of providers for audit including, but not limited to data analysis; fraud and abuse trends; identified vulnerabilities of the Program; external complaints of potential fraud or improper billing; and a provider's category of risk.

  OIG's internal audits may either be desk audits, field audits, self-audits, and self-disclosures. Desk Audits and field audits are conducted by BMI's program integrity auditors. Whereas, self-audits require Providers to review potential overpayment findings and self-disclosures require Providers to conduct their own investigations and review of their billing practices to identify potential overpayments.

  OIG's has oversight responsibility for external audits conducted by the Certified Public Accountant (CPA) Vendors, Recovery Audit Contractors (RAC) and the Universal Program Integrity Contractor

(UPIC). The Certified Public Accountant Vendors perform financial audits of Long Term Care Facilities. Federal law requires states to establish programs to contract with Recovery Audit Contractors to audit payments to Medicaid providers. The OIG uses RAC vendors to supplement its efforts for all provider and audit types. The federal Centers for Medicaid and Medicare Services' Center for Public Integrity offers states the use of UPIC auditors to perform targeted audits at no cost to the state. Both the internal and external audits may result in recoupment of overpayments, the entry of integrity agreements, termination from the program, or referral to law enforcement.

- **Recipient Restriction:** The Recipient Restriction Program (RRP) was established in an effort to ensure more effective utilization of medical and pharmacy benefits by recipients in the Medical Assistance Program. The concept of this program is that by assigning at-risk recipients to one Primary Care Physician, Primary Care Clinic and/or Primary Care Pharmacy the recipient will receive all medical care and coordination of their medical services (including referrals to specialists) by that primary provider. Emergency and inpatient hospital services are not restricted. Additionally, recipients with complex diagnoses involving many specialists are often left unrestricted as restricting them to one provider may impede the need for frequent and multifaceted care.

  The primary source of identifying recipient overuse is the selection algorithm in the Dynamic Network Analysis (DNA) Predictive Analytic model and profile-reporting system. By utilizing the DNA system for data that identifies specific recipients overutilizing medical or pharmacy benefits, the Recipient Analysis Unit (RAU) staff are able to analyze those cases for medical necessity. During their review process the recipient's medical usage for the preceding 24 months is reviewed. The analyst determines if the diagnoses listed on medical claims support the use of medical or pharmacy services received. When fraud, waste, or abuse of medical services is identified, the analysis is forwarded to the OIG Physician or Pharmacy Consultant for recommendations. When Medicaid benefits are determined to be overused or medically unnecessary, the Consultant will often place the at-risk recipients into a case management/care coordination system often referred to as the Recipient Restriction/Lock-In Program for 12 months. At the end of the 12-month restriction period the recipient's usage is re-evaluated. The restriction is released if utilization of services is appropriate or continued for an additional 24 months if overutilization has continued. This applies to recipients enrolled in both Fee for service and Managed Care Organization plans.

  Other sources of recipient identification include incoming referrals from medical providers, law enforcement officials, or members of the general public. All referrals are reviewed and analyzed.

- **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 is responsible for the enforcement of provider sanctions and represents the Department in provider recovery actions; actions seeking the termination, suspension, or denial of a provider's Program eligibility; state income tax delinquency cases; civil remedies to recover unauthorized use of medical assistance; and legal determinations affecting recipient eligibility for the OIG's LTC-ADI unit. OIG also assists with responses to Freedom of Information Act and subpoena requests.

During Fiscal Year 2019, the OIG successfully implemented legislative and enforcement initiatives that resulted in $257 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 2019

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
- 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
- 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 2019

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
- Extended services for pregnant women
- Eyeglasses
- Hospice services
- Inpatient psychiatric services for individuals under 21 years of age
- Intermediate care facility services for individuals age 65 and older in institutions for mental diseases
- 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 2017 - 2019 *Dollars in Thousands*						
	FY 2017 Expenditures	**Percent**	**FY 2018 Expenditures**	**Percent**	**FY 2019 Expenditures**	**Percent**
Total[1,2]	**$13,180,409.9**	**100.0%**	**$14,038,924.6**	**100.0%**	**$14,073,119.0**	**100.0%**
Hospitals	**1,888,213.7**	**14.3%**	**1,904,320.0**	**13.6%**	**1,222,586.3**	**8.7%**
Long Term Care[3]	**1,063,433.3**	**8.1%**	**980,484.5**	**7.0%**	**984,335.2**	**7.0%**
Practitioners	**506,770.7**	**3.8%**	**488,985.7**	**3.5%**	**278,453.0**	**2.0%**
Physicians	393,237.1	3. 0%	395,040.8	2.8%	218,624.6	1.6%
Dentists	94,902.6	0.7%	76,978.2	0.5%	50,994.4	0.4%
Optometrists	16,170.5	0. 1%	14,308.0	0. 1%	7,369.6	0. 1%
Podiatrists	2,381.6	0.0%	2,600.4	0.0%	1,449.1	0.0%
Chiropractors	78.9	0.0%	58.3	0.0%	15.3	0.0%
Drug	**1,205,783.4**	**9.1%**	**1,111,615.3**	**7.9%**	**894,689.1**	**6.4%**
Other Medical	**1,150,664.7**	**8.7%**	**1,090,678.8**	**7.8%**	**1,089,228.9**	**7.7%**
Laboratories	26,699.4	0. 2%	26,218.7	0. 2%	15,787.5	0. %
Transportation	44,414.9	0. 3%	41,297.5	0. 3%	43.379.1	0.3%
SMIB/HIB/ Expansion[4]	496,224.2	3. 8%	524,658.2	3. 7%	553,494.9	3.9%
Home Health Care/DSCC	128,672.4	1.0%	113,391.6	0.8%	141,330.4	1.0%
Appliances	48,481.9	0.4%	45,298.5	0.3%	32,445.5	0.2%
Other Related[5]	195.218.4	1.5 %	152,455.8	1.1 %	176,321.5	1.3 %
Community Health Centers	137,226.0	1.0%	128,650.2	0.9%	62,246.0	0.4%
Hospice Care	73,727.5	0.6%	58,708.3	0.4%	64,224.0	0.5%
MCOs	**7,365,544.1**	**55.9%**	**8,462,840.3**	**60.3%**	**9,603,826.5**	**68.2%**
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 2019.

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.