FY13 Medicaid Liability and Spending Reductions:
Governor's Proposal to General Assembly, April 19, 2012

Dollars in Thousands

Item #	Category	Item Name	Proposed Change	Reason	Gross Savings	Comments
1	Eligibility	Family Care adults	Reduce eligibility to 133% FPL; eliminate coverage for grandfathered adults 185%-400%	133% will be the national standard for Medicaid under the Affordable Care Act, effective 1/1/14. Medicaid is not enrolling parents and other caretakers with income 185%-400% FPL; current group includes only persons enrolled at the end of June 2009, and federal match is not available for the costs of covering this population.	$49,884.7	Impacts approximately 26,400 clients. Average annual cost per client: $1,890.
2	Eligibility	General Assistance adults	Eliminate coverage for all clients	State-only program. Could move clients to Cook County 1115 waiver, if approved by GA and federal CMS.	$16,681.3	Impacts approximately 9,160 clients. Average annual cost per client: $1,821.
3	Eligibility	IL Cares Rx	Terminate program	State-only program. Other states dropped coverage when Medicare D became available. National healthcare reform law is providing more assistance for drug costs in "donut hole". Federal program, "Extra Help/Low Income Subsidy", provides federal assistance for low-income seniors.	$72,154.0	Impacts approximately 180,000 clients.
4	Eligibility	Enhanced eligibility verification	Conduct full review of ongoing eligibility in Medicaid program	Important to ensure that clients do not remain on the Medicaid rolls when they are no longer eligible.	$120,000.0	This effort includes conducting required annual redeterminations, and cancelling cases for clients with out-of-state address, those with income over the Medicaid income standard, those who are deceased, or children aging out of the AllKids Program at age 19. It will require human resource and systems investments at HFS.
5	Optional Service	REACH Program	Terminate contract effective 06/30/12	Program is at risk of losing federal match	$3,000.0	Cost to Dept. on Aging as clients shift to Community Care program. Impacts approximately 240 participants.
6	Optional Service	Group psychotherapy for NH residents (and related transportation)	Eliminate services	Despite some controls, there continues to be overuse of this service. If needed, psychotherapist should come to nursing home.	$14,256.1	10,420 distinct recipients in FY 2011.
7	Optional Service	Pediatric palliative care	Repeal law before it is implemented	State cannot afford to begin a new optional service. No clients are affected.	$4,500.0	Colorado study - spending almost $15M. Estimated to impact approximately 1,000 clients.
8	Optional Service	Adult eyeglasses	New policy: one pair every 2 years	Limit to 1 pair every 2 years would be in line with other payors.	$509.9	First year savings figure. Second year savings figure of $9,819.5. Statute requires coverage for persons participating in DHS educational or work programs. For the remaining population, the service is optional.

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9	Optional Service	Adult chiropractic	Eliminate	For adults, currently there is no review of diagnosis or limits on number of sessions. HFS will also implement reviews to ensure appropriate services to children.	$884.5	Impacts approximately 9,600 clients.
10	Optional Service	Adult speech, hearing and language therapy services	Eliminate payments for individual providers.	Set annual maximums of services per year and reimburse only through home health providers.	$411.0	Impacts approximately 500 clients.
11	Optional Service	Adult occupational therapy services	Eliminate payments for individual providers.	Set annual maximums of services per year and reimburse only through home health providers.	$596.7	Encourages utilization control and covers therapies to keep clients in their homes.
12	Optional Service	Adult physical therapy services	Eliminate payments for individual providers.	Set annual maximums of services per year and reimburse only through home health providers.	$2,544.9	Encourages utilization control and covers therapies to keep clients in their homes.
13	Optional Service	Hospice	Assume 10% reduction through utilization controls	Hospice costs have risen substantially in last 5 years.	$10,015.3	Continuing work with provider association to analyze budget and potential savings.
14	Optional Service	Adult dental	Eliminate	Adult dental is an optional service for restorative treatments; it does not cover preventive measures. Many health plans, including Medicare, do not include dental services.	$51,428.2	Impacts approximately 172,000 clients.
15	Optional Service	Dental grants	Eliminate new grants for FY13	State-only grants could be replaced by capital grants for dental clinic equipment (e.g. dental chairs, etc.)	$1,000.0	
16	Optional Service	Adult podiatry	Limit service to diabetics	Retain adult podiatry for nail maintenance and other foot conditions for persons with diabetes. Eliminate service for other adults.	$5,200.0	
17	Optional Service	Durable medical equipment	Assume a 10% reduction through utilization controls	DME costs have risen substantially in the last 5 years.	$15,008.8	Continuing work with provider association to analyze budget and potential savings.
18	Optional Service	Home health	Assume a 10% reduction through utilization controls	Home health costs have risen substantially in the last 5 years.	$11,000.0	Continuing work with provider association to analyze budget and potential savings.
19	Utilization Controls	Hospitals: Detox services in acute hospitals	No readmission within 30 days; authorize 12.5+ hour observation only	Most state Medicaid programs do not offer inpatient detox services. There were 22,000 inpatient admissions in CY2010, where substance abuse was key reason for admission, at average cost of $2,000. Unlikely that these clients are engaged in a serious regimen of rehabilitation.	$25,492.4	Estimate assumes 70% of detox services without complications would be done in observation setting.

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20	Utilization Controls	Hospitals: baby deliveries	No pay for scheduled c-sections prior to 39 weeks - unless medically necessary; pay only normal vaginal delivery rate.	Advocates for improving birth outcomes have national campaign to reduce incidence of scheduled (elective) deliveries <39 weeks. Best outcomes are achieved when babies are born at full-term via normal vaginal delivery.	$2,854.0	
21	Utilization Controls	Bariatric (weight loss) surgery	Impose utilization controls	Adopt Medicare standard with patient responsibility (six-month medically supervised weight loss program under primary care physician) and surgery at a Center of Excellence.	$3,000.0	Impacts approximately 1,320 clients.
22	Utilization Controls	Eligibility for nursing facilities - change DON from 29 to 37 for new admissions only	Change DON from 29 to 37	Determination of Need (DON) is tool used for seniors and people with physical disabilities applying for nursing facilities and supportive living facilities (SLF - see #24 below). Policy will target Medicaid long-term care dollars to clients with highest needs. New DON score would apply to applicants for nursing facilities and SLFs in HFS budget; also for applicants for all home and community-based Medicaid programs administered by sister agencies, Depts. of Human Services and Aging.	$4,400.0	Assumes a 6 month FTE impact. Savings based upon approximately 1,000 new admissions below a 37 DON score.
23	Utilization Controls	Eligibility for supportive living facilities (SLF) - change DON from 29 to 37 for new admissions only	Change DON from 29 to 37	same as above	$3,300.0	Savings based upon approximately 1,300 projected new admissions below a 37 DON score.
24	Utilization Controls	Ambulance services	Repeal law requiring ambulance transportation between 24-hour medically monitored institutions (i.e. hospitals/nursing homes). Continue process of clarifying standards and prior approvals for ambulance transports.	Recent law and IDPH rule require full ambulance for transport from one facility with 24-hour medical monitoring to another such facility; adds excessive and unnecessary cost to transportation budget.	$1,500.0	Impacts approximately 30,000 clients.
25	Utilization Controls	Wheelchair repairs	Require prior approval on wheelchair repairs	Current administrative rule states repairs do not require prior approval as long as the repair is less than 75% of the purchase price.	$800.0	

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26	Utilization Controls	Pharmaceuticals - prescriptions in Long Term Care settings	Require pharmacies to dispense brand name drugs in days' supply of less than 30 days for recipients in long term care settings	Changes policy based on Medicare rule. Pharmacies typically dispense maintenance medications to residents of long-term-care settings in 30-day supplies, but this leads to waste when a resident dies, changes medications, is hospitalized, or otherwise leaves the facility.	$150.0	Medicare Part D implemented a policy effective 1/1/2012 requiring pharmacies to dispense drugs in 7-day rather than 30-day supplies for LTC residents, initially limited to brand name drugs as a transitional approach. HFS will implement similar policy. Impacts approximately 1,000 clients.
27	Utilization Controls	Hospital readmissions	Establish performance-based payment system related to "potentially preventable events"	HFS is in process of establishing benchmarks for hospitals to measure and align payments to reduce hospital admissions/readmissions, inpatient complications and unnecessary ER visits. Modeled on Medicare policy to take effect 10/1/12.	$40,000.0	Suggested by and cost estimate furnished by IHA
28	Utilization Controls	Pharmaceuticals - limits on adult prescriptions	Limit adult prescriptions to five per month - but can be increased based on prior authorization	Prescription drugs are an optional service under Medicaid, but are needed to help clients with acute and chronic medical conditions. Currently, there is no limit on the number of prescriptions a client can fill. Our plan would limit prescriptions to 5 without doctor certification of need, reducing unnecessary medication and negative drug interactions.	$136,000.0	Impacts approximately 200,000 clients.
29	Utilization Controls	Pharmaceuticals - limits on children's prescriptions	Limit children's prescriptions to five per month - but can be increased based on prior authorization	Same as above. It is believed that children with more than 5 prescriptions will benefit from a physician's review of possible overuse and negative consequences of interactions among	$10,000.0	Impacts approximately 47,000 clients.
30	Utilization Controls	Pharmaceuticals - medication therapy management	Pilot project to test effectiveness	Pharmacists suggest cost savings when the pharmacist is incentivized to provide consumer education and care coordination services.	$500.0	Proposed by IRMA.
31	Utilization Controls	Pharmaceuticals - cost avoidance	Cost avoidance at point of sale. Reject claims where a patient has a third party payer that has not been billed primary	Change from pay-and-chase model: reject pharmacy claims at the point-of-sale for patients with other coverage when the pharmacy has not first billed the liable third party.	$40,000.0	Impacts approximately 155,000 clients with other insurance than Medicaid.

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32	Utilization Controls	Pharmaceuticals - hemophilia protocols/clotting factor reimbursement	New protocols for treatment of hemophilia patients; new reimbursement methodology for clotting factor products	Policy will target this expensive medical condition to achieve better disease management and reduced spending on blood factor. Policy will reduce practice where hemophilia patients will fill more blood factor than is necessary.	$11,995.3	HFS spends over $40M on blood factor each year for 250 Medicaid clients with hemophilia. In the state-only hemophilia program, HFS covers another 250 clients, and spends about $19M (costs less because many have primary insurance and use the program only after they have reached their cap with their primary insurance).
33	Utilization Controls	Pharmaceuticals - combination HIV medications	Implement prior approval requirement for combination HIV medications. Require patients to fill each individual drug separately.	Requiring prior approval for combination products will shift utilization to less expensive individual products for patients without compliance concerns, and will have no adverse impact. In patients where adherence is a concern, HFS would approve the combination products.	$3,000.0	Impacts approximately 4,500 clients.
34	Utilization Controls	Pharmaceuticals - cancer/biologicals	Implement prior approval, utilization limits and pricing strategies on certain physician administered drugs	To incent choice of lower cost drugs and to avoid improper use of high cost drugs administered by physicians	$5,000.0	Impacts approximately 10,000 clients.
35	Utilization Controls	Pharmaceuticals - transplants medications	Require prior approval for brand immunosuppressive products that have generic equivalents. Work with hospitals to initiate immunosuppressive drug therapy for transplant patients with generic drugs, rather than expensive, brand name drugs.	Cost savings for ongoing maintenance medication will be achieved if the patient is put on a regimen of less expensive drugs when first prescribed in the hospital.	$2,700.0	Proposed by IRMA.
36	Utilization Controls	Intermediate Care Nursing Facilities - Moratorium	Moratorium on new admissions to intermediate care nursing facilities	Care for "intermediate care" residents in nursing facilities -- who in Illinois tend to be people with mental illness -- is an optional service. Rather than eliminating the service and discharging current residents, this policy would put a moratorium on new admissions. Focuses resources of Medicaid program on higher-need clients who need residential placements.	$114,100.0	Impacts about 14,900 new admissions per year.

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37	Utilization Controls	Institutions for Mental Disease - Moratorium	Moratorium on new admissions to institutions for Mental Disease (IMD) - state-only program	State-only program for people with mental illness. Rather than eliminating this optional service and discharging current residents, this policy would put a moratorium on new admissions. Focuses resources of Medicaid program on higher-need clients who need residential placements.	$36,851.2	Impacts approximately 1,800 new admissions per year.
38	Utilization Controls	Veterans' benefit enhancement	Move services to federal VA for qualifying veteran clients	Offset Medicaid costs by shifting eligible veterans to better services provided by federal VA facilities.	$2,000.0	Proposed by Illinois Department of Veterans Affairs; there will be administrative impact for that department's veterans services officers.
39	Utilization Controls	Incontinence supplies	Quantity limit of 200 per month (from 300)	Cost savings are achieved through prevention of overuse, and accumulation of unused supplies.	$5,000.0	Cost savings based on quantity limit of only 200 combination of diapers or briefs (includes kids).
40	Cost Sharing	Hospital co-pay non-emergent use of emergency room services	Impose a $10 co-pay for non-emergency use of emergency room services.	Creates an incentive for clients to avoid inappropriate use of emergency room services.	$9,000.0	Proposed by IHA and 2011 Medicaid reform law. Cost savings estimate provided by IHA.
41	Cost Sharing	Pharmaceuticals - co-pays	Co-pays for generics - consider waiver to federal government for all incomes	Currently, for adults, brand name drugs require a $3 co-payment and generic drugs have no co-payment. Requiring a co-payment for generic drugs for adults would generate significant savings, and would also help ensure patients fill only those prescriptions that they need.	$14,300.0	Impacts approximately 900,000 clients. Savings value assumes a $1 co-pay.
42	Cost Sharing	Children receiving home services in Medically Fragile/Technology Dependent (MFTD) Medicaid Waiver	Changes in waiver to reflect cost-sharing based on parental income and new flexible rules for families, reducing utilization	Cost savings are achieved through cost-sharing, as allowed by federal law, and through incentives for consumer-directed care that offers flexibility.	$15,000.0	Waiver expires 8/1/12; policy decision (in statute) must be made during spring session.

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43	Cost Sharing	Federally Qualified Health Centers	Require co-pays	Incentivize proper service utilization through requiring clients to cover part of the expense.	$2,919.3	Implement for clients currently subject to co-pays, but for services not already subject to co-pays. Reflects value of a $3 co-pay increase.
44	Rate Adjustment	Long term acute hospital (LTAC) rates for ventilator-dependent patients	Rewrite recent law that substantially increased rates, with annual rate increases	Adjust the rates for clients requiring ventilator services in 7 long term acute hospitals to rates that are commensurate for similar patients receiving similar services in nursing facilities (highest rate). Recent law in IL increased base rates substantially for LTACs, which, if they now comply with several requirements, can receive adjustments up to 190% of their base rates or payments of $1,745 per day.	$39,600.0	Assumes 50% of days converted to the LTC rate.
45	Rate Adjustment	Federally Qualified Health Centers	Eliminate need for HMO wrap-around payment	Require managed care organizations (MCOs) to pay FQHCs full cost, so that state has no obligation to pay wrap-around payments. MCO rates are built upon full FQHC costs.	$13,200.0	
46	Rate Adjustment	Nursing Facility - capital rate	Lower the return on investment percentage in the capital portion of the nursing facility rate	Policy assumes a more reasonable 4% return on investment than currently.	$71,125.5	
47	Rate Adjustment	Nursing Facility - nursing rate	Eliminate $10 add-on for clients with DD	Based on a 22-year old policy from 1990, there is no remaining service requirement for this add-on, which was originally created for specialized services programs.	$472.0	Impacts approximately 130 clients.

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48	Rate Adjustment	Excellence in Academic Medicine	Eliminate	State can no longer afford these extra payments to 11 teaching hospitals.	$13,800.0	$13.8 million gross GRF impact. $27.6 million gross all funds impact.
49	Rate Adjustment	Nursing Home/SLF bed holds	Eliminate bed hold for adults age 21 and over in LTC, including SLFs	There is no justification for additional reimbursements for nursing facilities and supportive living facilities for holding beds for Medicaid clients during periods of temporary absence (i.e. hospital admission).	$8,305.0	
50	Rate Adjustment	Supportive Living Facility rates	Delink rate increase from new nursing home tax funded nursing home rate increase	Without a rule change, SLFs will receive an automatic rate increase from the recent assessment-funded nursing home rate adjustment; SLF rates are set at 60% of nursing home rates (same for hospice).	$20,800.0	
51	Rate Adjustment	Power wheelchair rates	Reimburse for power wheelchairs at actual purchase price rather than current practice of Medicare rate minus 6%.	Allow for equitable payments to providers while saving HFS money.	$1,900.0	
52	Care Coordination	Initiatives being launched in FY13 include: Integrated Care Program Phase II, Dual Eligibles Capitation Demonstration, Innovations Program - adults, Innovations Program - children	Focus on most expensive clients with complex health/behavioral health needs	Care coordination is most important and cost-effective plan for improving Medicaid service delivery, and is required by 2011 Medicaid reform law (50% of clients by 1/1/15). Modest savings in FY13 are assumed due to mid-year implementation, start-up delays and gradual enrollment of clients.	$16,075.0	In addition to $16 million projected cost savings, FY13 budget already assumes $23 million in savings related to Phase I of Integrated Care -- or $39 million in total.
53	Other	Recipient Eligibility Verification Vendors (revenue item)	Increase the number of vendors with connections to HFS systems and increase fees for transactions processed through those connections.	In order to require electronic verification of eligibility by providers at the point of service, HFS will allow more entities to have direct system connections to HFS data, will increase the number of transactions for which it charges a fee and will increase the fees charged.	$1,000.0	

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54	Other	Reform private insurance market	Increase the number of children with special healthcare needs who have their needs met with private insurance -- who now use both private insurance and Medicaid.	Goal is to share responsibility with the health insurance industry for covering children with special needs. Under federal law, these children can no longer be excluded on the basis of preexisting conditions, but the coverage needs to be expanded to allow families to keep children in the home with the proper supports.	$250,000.0	More realistic possible savings related to Children's Memorial Hospital proposal.
55	Other	Hospital outpatient drugs - rebates (revenue item)	Reimburse hospital outpatient drugs separately in order to collect manufacturer rebates.	Hospitals are now reimbursed for outpatient drugs through established outpatient hospital rates. If payments for outpatient drugs are segregated and made separately, it would make that spending eligible for manufacturer rebates. Inpatient drugs are not eligible for rebates.	$20,000.0	Proposed and cost savings estimate developed by IHA.
56	Other	Third party liability	Contract with vendor to enhance HFS' current collections efforts.	Implement 2011 Medicaid reform. Invitation for Bids was published on March 19, 2012. Bids are due on April 21, 2012.	$10,000.0	
57	Other	Recovery audit contractor (RAC)/payment recapture audits	Implement RAC audits as a supplement to Inspector General's reviews.	Under federal Affordable Care Act rules and 2011 Medicaid reform law, HFS will contract with Recovery Audit Contractors (RAC) to audit payments to medical providers. Focus will be on provider types not currently under close scrutiny.	$21,875.0	Estimated gross savings of $25 million is offset by an assumed contingency fee of 12.5 percent (maximum allowed by federal rules - could be less), or $3.125 million.
58	Other	Improving birth outcomes	Develop a statewide multi-agency initiative to improve birth outcomes and reduce costs associated with babies being born with low and very low birth weight and fetal death	Illinois will use successful Michigan model of intensive care coordination for high-risk pregnant women and mothers.	$25,000.0	
			Grand Total		**$1,382,090.2**	
	Note:					
	Savings figures reflect 12 month values and assume a July 1, 2012 date of service start date unless otherwise noted. The figures will need to be modified for any change to that date and for provider billing lags.				