The below details a preliminary breakdown of Illinois Governor Bruce Rauner’s Fiscal Year 2016 (FY16) Proposed Budget for the Medicaid Program.

Overall, the Governor’s proposed FY16 Budget cuts the Medicaid Program by $1.4 billion and proposes no new revenue.

As you likely know, the details of this proposed budget will continue to become clearer in the days and weeks ahead so please keep in mind that the below is an initial view of information released by the Governor’s office for his proposed FY16 budget address given on February 18, 2015.

Best,
Nadeen

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Governor Bruce Rauner’s Fiscal Year (FY) 2016 Proposed Budget - Medicaid Program

Proposed Cuts include:

1. Rates and services (added back after SMART Act, primarily through SB741 in 98th GA, signed June 2014)
   - Roll back nursing home rate increase, $215.8 million
   - Elimination of adult dental – $32 million
   - Roll back Supportive Living Facility (SLF) increase - $13.8 million
   - Roll back increased reimbursement to ambulance providers – $13.8 million
   - Cut renal dialysis – $13.8 million
   - Eliminate safety net hospital add ons – $9.2 million
   - Roll back increased home health rate – $5.5 million
   - Elimination of adult podiatry services – $4.6 million
   - Eliminate exceptions to four-script limit, including psychotropic drugs carve-out that happened in SB741 and carve-out of kids in complex care CCEs - $4.6 million
   - Roll back rates proposed for Specialized Mental Health Rehabilitation Facilities (SMHRFs) (new name for Institutes for Mental Disease (IMDs)) – $3.7 million
   - Roll back new rate increase for child psychiatric hospitals – $3.7 million
   - Roll back rate increase for transitional care facilities - $0.5 million

2. Cuts to "optional" services and rates
   - Eliminate funding for IMDs – $74.7 million
   - Eliminate care coordination fees to ACEs and CCEs – $60 million
Reduction in Medicaid managed care rates (impacting MCOs and MCCNs) – $54.9 million, ~1.5% depending on population being served
- Program changes will result in lower rates as well for MCOs and MCCNs
- Decrease pharmacy dispensing fee for brand and generic by $2.40/drug – $46.2 million
  - This would result in a $0 dispensing fee for brands and $3.10 for generic
- Tightening Durable Medical Equipment (DME) and supplies contracts and usage – $29.8 million
- Eliminate renal dialysis for non-citizens – $9.3 million
- Eliminate kidney transplants for non-citizens – $7 million
- Raise Determination of Need (DON) score as state moves towards Universal Assessment Tool (UAT) for Long-Term Services (LTS) eligibility – $7.1 million
- Reinstate therapy limits from SMART Act – $1.6 million

3. Program integrity – ensuring timely Medicaid eligibility redeterminations/renewals $53 million
- Savings comes from catching up with Medicaid eligibility redetermination/renewal caseload
- Increased resources to Inspector General to combat provider and recipient fraud - $21.5 million

4. Eligibility reductions
- Eliminate Medicaid under Illinois Breast and Cervical Cancer Program (IBCCP) - $32.3 million
  - Idea is that most of these people can move to Health Insurance Marketplace
- Eliminate state hemophilia program – $4.6 million
  - Idea is that most of these people should go to the Health Insurance Marketplace – HFS said they actually spend very little in this state program now, $4.6 does not represent reduction of services, just appropriations
- Eliminate state renal program – $100,000
- Eliminate All Kids eligibility for kids who already have private insurance (for kids in Share and Premium levels, 150-300% FPL) All Kids - $2.9 million
  - This cut will impact about 4300 kids; most likely use this coverage for dental services for kids
  - This should not impact Medically Fragile Technology Dependent (MFTD) waiver children at all because income is waived for these kids
- Eliminate Health Benefits for Workers with Disabilities – $1.4 million

5. Proposed changes to hospital static payments
- Elimination of current GRF payments – these payments are not tied to any specific services - $334.9 million
- Take $400 million of payments to hospitals that are static payments funded by hospital assessment and use this amount to pay claims-based hospital payments – start paying for services instead of lump sum payments to hospitals
  - The idea is to redirect these dollars to pay for general Medicaid services instead of only to hospitals;
  - The "ACA $400 million" payments to hospitals should help offset this proposed change
• $12.5M operational savings to HFS

• Some of these cuts to the Medicaid Program will require legislation, some rules changes, some State Plan Amendments (SPAs)