HFS
Illinois Department of
Healthcare and Family Services

JB Pritzker, Governor
Elizabeth M. Whitehorn, HFS Director

FY2023

ANNUAL REPORT

Medical Assistance Program

April 1, 2024

HealthChoice
Illinois

A LETTER FROM THE DIRECTOR

Elizabeth M. Whitehorn, Director

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

On behalf of the Department of Healthcare and Family Services (HFS or Department), I am pleased to present the Fiscal Year 2023 Annual Report of the Department's medical assistance programs, which includes Medicaid, the Children's Health Insurance Program (CHIP), All Kids, and other special eligibility programs.

Every day we advance our mission, providing access to high- quality healthcare for more than three million Illinoisans. In doing so, we continue to consider equity as the foundation of our work and empower our customers to maximize their health and well-being.

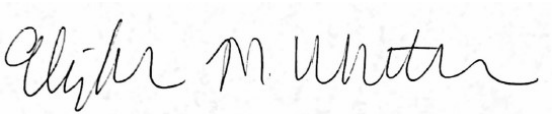
As this report sets forth, the department continues utilizing its quality framework to offer our customers innovative healthcare solutions. We recognize that our customers come to us with a range of needs and goals and we constantly work to meet these as directly as possible.

A central challenge in the past fiscal year has been responding to the end of the Medicaid continuous enrollment period established during the COVID-19 Public Health Emergency. The Department committed to a multi-platform campaign to help eligible customers retain their coverage. The initial results of this effort led to Illinois experiencing one of the lowest Medicaid disenrollment rates nationwide.

Beyond helping ensure those eligible for coverage retain their healthcare, HFS has been developing and launching new and enhanced services. These include the HFS Family Planning Program, nursing home rate reform, expanding the number of Healthcare Transformation Collaboratives, and programs to promote community care and to assist youth and children with complex behavioral health needs.

This report provides details on these and many other specific initiatives, as well as participant numbers and provider reimbursements for Fiscal Year 2023 (and, in some instances, for the two previous years for purpose of comparisons and statutory requirements).

Building on a foundation of person-centered and equity-driven programs, we look forward to collaborating with our stakeholders to expand services and improve current operations for our state's most vulnerable residents.



Sincerely,
Elizabeth M. Whitehorn, Director

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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.

We Improve Lives.

- We address social and structural determinants of health.
- We empower customers to maximize their health and well being.
- We provide consistent, responsive service to our colleagues and customers.
- We make equity the foundation of everything we do.

COVERAGE

In fiscal year (FY) 2023, the Department provided medical coverage to nearly one-third of the state's population. Enrollment as of June 30 for the last three completed fiscal years (Illinois' FY is from July 1 to June 30) is as follows:

Comprehensive Benefits	FY2021	FY2022	FY2023
Children	1,465,904	1,499,514	1,542,115
Adults with Disabilities	252,650	246,842	250,817
ACA Newly Eligible Adults	774,007	868,108	939,005
Other Adults	640,548	741,991	867,262
Seniors	260,929	288,600	336,269
Total Comprehensive	3,394,038	3,645,055	3,935,468
Partial Benefit Enrollees	46,467	47,275	46,499
Total Enrollees	**3,440,505**	**3,692,330**	**3,981,967**

HEALTH CARE PROGRAMS

The following are the healthcare programs administered by HFS. For more information about these programs and how to apply, visit the Illinois Application for Benefits Eligibility (ABE) web-based portal at: ***https://abe.illinois.gov/abe/access/***.

All Kids Assist

Eligibility - Children up to age 19 with family income at or below 318% of the Federal Poverty Limit (FPL) ($7,950 per month for family of four (4)).
Presumptive Eligibility[1] - Yes **Benefit** - Comprehensive **Cost Sharing** - No

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** - No

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 $5,325 a month for a family of four (4) that includes 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 ($3,450 per month for a family of four (4)) for adults.
Presumptive Eligibility - No **Benefit** - Comprehensive **Cost Sharing** - Yes

[1] Presumptive eligibility provides immediate, temporary medical coverage to customers when certain criteria are met

ACA Adults

Eligibility - Adults ages 19-64 without minor children in the home who do not receive Medicare and have income up to 138% FPL (monthly income up to $1,677 for an individual or $2,268 for a couple).
Presumptive Eligibility - Yes **Benefit** - Comprehensive **Cost Sharing** - No

Aid to Aged, Blind and Disabled (AABD)

Eligibility - Persons who are 65 and older, who are blind, or who are disabled, with monthly income up to 100% FPL ($1,215 for a single person and $1,643 for a couple) and no more than $17,500 of non-exempt resources.
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, ages 16-64, with disabilities and earnings up to 350% FPL ($4,253 per month for an individual, $5,752 per month for a couple) who buy into Medicaid by paying a small monthly premium. May have up to $25,000 in non-exempt resources.
Presumptive Eligibility - No **Benefit** - Comprehensive **Cost Sharing** - Yes

Health Benefits for Persons with Breast or Cervical Cancer

Eligibility - Individuals under age 65 without insurance that covers cancer treatment and whose breast or cervical cancer diagnosis has been confirmed by the Department of Public Health (DPH). 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 ages 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 - Individuals who are not U.S. citizens or do not have a legal immigration 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 healthcare program.
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 (SLIB), and Qualified Individual (QI-1). Income limits vary per program; however, income is less than or equal to 135% FPL plus $25 (monthly SSI income disregard). Resource limits are $9,090 for a single person and $15,160 for a couple.
Presumptive Eligibility - No **Benefit** - Coverage of Medicare cost sharing expenses
Cost Sharing - Not Applicable

Health Benefits for Immigrant Adults (HBIA)

Eligibility - Illinois residents ages 42 through 64 whose immigration status does not meet the requirements for coverage under another eligibility group.
Presumptive Eligibility - No **Benefit** - Partial **Cost Sharing** - Yes

Health Benefits for Immigrant Seniors (HBIS)

Eligibility - Illinois residents aged 65 and over whose immigration status does not meet the requirements for coverage under another eligibility group. Eligibility criteria is otherwise similar to AABD.
Presumptive Eligibility - No **Benefit** - Partial **Cost Sharing** - Yes

Family Planning (FP)

Eligibility - Illinois residents of any age or gender who are U.S. citizens or qualified immigrants who are not enrolled in Medicaid. Applying individual counted in household of their own (given a household size of 2) with income up to 213% of FPL.
Presumptive Eligibility - Yes **Benefit** - Family Planning and Family Planning related services.
Cost Sharing - No

The following are the healthcare services administered by HFS for customers who are otherwise ineligible for medical assistance coverage and for which providers submit claims directly to HFS for payment.

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

Customer Hotline Numbers

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

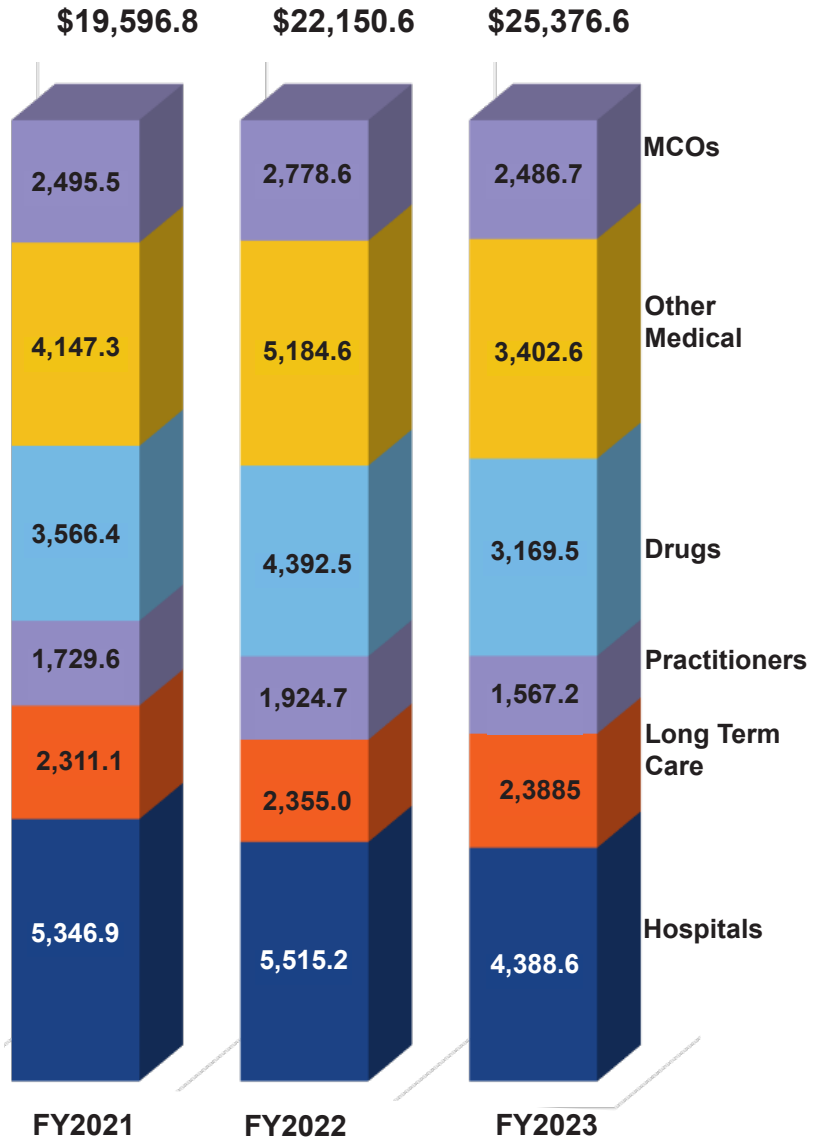
Crisis Referral and Entry Services (CARES) *Behavioral Health crisis dispatch hotline*	1-800-345-9049 TTY: 773-523-4504
All Kids	1-866-255-5437
Client (Illinois Health Benefits & All Kids Hotline)	1-800-226-0768
Drug Prior Approval/Refill-Too-Soon	1-800-252-8942
4 Our Kids (Medical Programs Health Benefits & All Kids Hotline)	1-866-468-7543
Customer eligibility verification *Automated Voice Response System (AVRS) that verifies an individual's medical assistance program coverage*	Customers: 1-855-828-4995 Providers: 1-800-842-1461
Prior Approvals	1-800-642-7588
Drug Prior Approval/Refill-Too-Soon	1-800-252-8942
TTY (for hearing impaired) Handled by Next Talk	1-877-204-1012
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, Kids Now connects to the Illinois Health Benefits & All Kids Hotline*	1-877-543-7669

PROGRAM COSTS

During FY2023, HFS spent approximately $32.13 billion (all funds), of which $25.38 billion was from the General Revenue Fund (GRF) or GRF-related funds for customer health benefits and related services. (See Table II in appendix for HFS FY2023 spending by appropriation line).

Medical Programs Spending

FY2021 - 2023 Dollars in Millions



A summary of the factors contributing to the most significant changes in medical assistance program spending from FY2021-FY2023 is provided below.

2021 - Enrollment has increased over 11% during the COVID-19 Public Health Emergency (PHE). HFS instituted a supplemental rate increase for Ground Emergency Medical Transportation.

2022 - Enrollment increased over 7% during the PHE. Medicare Part D clawback increased due to calendar year (CY) 2022 rate and enrollment increases. The clawback is a monthly payment made by the state to the federal Medicare program. The state's amount roughly reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of customers dually eligible for Medicare and Medicaid. Other increases were due to CY2022 federal rate increases for Medicare Parts A & B Premiums, an over $350 million increase for hospital pandemic surge staffing, and the shift of emergency medical transportation costs from managed care organization (MCO) capitated rates back to fee-for-service (FFS) rates.

2023 - Enrollment continues to increase during Public Health Emergency, over 6.5% increase during FY2023. The Health Benefits for Immigrant Adults & Seniors Program continued to enroll people which reflected in an increase within fee for service claims. Medicare Part D Clawback increased due to calendar year 2023 rate & enrollment increases. A one-time $490 million hospital stabilization & community mental health service payments were issued to providers.

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, Juvenile Rehabilitation Services, and Coronavirus Urgent Remediation Emergency Funds. "MCOs" includes administrative fees and $1 billion in capitation payments financed by the MCO assessment, which supports additional Medicaid spending that would otherwise come from General Funds. MCO capitations are generally allocated to provider types (Other Medical, Drugs, Practitioners, Long Term Care and Hospitals) based upon that fiscal years MCO encounter data."Other Medical" refers to Laboratories, Transportation, Medicare A & B Premiums, Home Health Care/DSCC, Appliances, Other Related Supplies and Equipment, Community Health Centers Medically Complex Development (MCDD), and Hospice Care.

Numbers may not appear to add due to rounding. Data Source: Division of Finance, Comptroller Spending Report FY'21-'23.
Graph Prepared By: Division of Finance

Through its role as the designated single state Medicaid agency, HFS works with several other agencies that manage important portions of the medical assistance programs including: the Department of Human Services (DHS), DPH, DCFS, the Department on Aging (DOA), the University of Illinois Chicago's Division of Specialized Care for Children (DSCC), the University of Illinois Office of Medicaid Innovation (OMI), 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 (SSA).

TRANSFORMATION

TRANSFORMING MEDICAL ASSISTANCE

While ensuring that ongoing medical assistance programs continued to operate effectively, the Department drove a range of advances and new initiatives to respond to evolving needs and challenges throughout Illinois.

In FY2023, HFS developed and expanded programs such as Pathways to Success (for youth and children with complex behavioral needs) and the Healthcare Transformation Section 1115 Demonstration Waiver (to help reorient our healthcare system around people and communities). Other major program accomplishments include:

End of COVID-19 PHE/Continuous Coverage
To help eligible customers remain covered after the end of the COVID-19 PHE Medicaid continuous enrollment period, HFS launched a multi-platform awareness campaign. This effort has included mailings, paid advertisements, print, digital and broadcast communication, and grassroots outreach.

HFS Family Planning Program
Effective in November 2022, the Department launched the HFS Family Planning Program, a new category of medical coverage for Illinoisans, offering limited medical coverage for reproductive health and family planning related services.

Nursing Home Rate Reform
HFS began implementing major rate reform for the over 650 nursing facilities that receive Medicaid funding. These reforms include nationally unprecedented levels of performance-based funding to reward facilities demonstrating higher direct care staffing levels, higher quality care, and adoption of Certified Nursing Assistant (CNA) experience and promotion wage scale. As a result, data demonstrates that Illinois nursing facilities have shown meaningful improvements, such as staffing ratios rising faster than any state in the country.

Healthcare Transformation Collaboratives (HTCs)
Launched in 2021, equity-driven HTCs are designed to create partnerships to bridge gaps in the healthcare delivery system and increase access to quality healthcare services in underserved communities across Illinois. New HTCs were chosen in FY2023, bringing the total number to 15.

Program of All-Inclusive Care for the Elderly (PACE)
PACE is designed to better meet the needs of older adults across Illinois by expanding options for community-based care. Providers are being enrolled and trained, with services to be offered beginning in 2024.

Comprehensive Medical Programs Quality Strategy

In accordance with federal managed care regulations (42 CFR §438.340), in CY2020 the Department developed a transformative, person-centered, integrated, equity-focused Comprehensive Medical Programs Quality Strategy (Quality Strategy) designed to improve outcomes in the delivery of healthcare at a community level.

The Quality Strategy is designed to foster the delivery of the highest quality, most cost-effective services possible by establishing a framework for the ongoing evaluation of performance and the identification of opportunities for improvement. Within this framework, five pillars for improvement were selected, serving as guideposts for the development of HFS' vision for improvement and program goals (outlined in the table below).

HFS is Committed to Improving Health Outcomes and Equity		
Pillar 1: Maternal & Child Health		**Improve Maternal & Infant Health Outcomes** • Reduce pre-term birth rate and infant mortality • Improve the rate and quality of postpartum visits • Improve well-child visits rates for infants and children • Increase immunization rates forinfants and children
Pillar 2: Adult Behavioral Health		**Improve Behavioral Health Services and Supports for Adults with Mental Illness** • Improve integration of physical and behavioral health • Improve transitions of care from inpatient to community-based services • Improve care coordination and access to care for individuals with alcohol and/or substance abuse disorders
Pillar 3: Child Behavioral Health		**Improve Behavioral Health Services and Supports for Children with Mental Illness** • Improve integration of physical and behavioral health • Improve transitions of care from inpatient to community-based services • Reduce avoidable psychiatric hospitalizations through improved access to community-based services • Reduce avoidable emergency department visits by leveraging statewide mobile crisis response
Pillar 4: Equity		**Improve Health Equity** • Focus on health equity • Improve preventive screening • Use data to identify target areas, in priority regions, where disparities in optimal out- comes are the highest
Pillar 5: Community Based Services & Supports		**Improve Community Based Services and Supports by Serving More People in the Settings of their Choice** • Increase the percentage of older adults and people receiving institutional care (nursing facilities) to community or home-based programs to maximize the health and independence of the customer

To drive progress towards these identified program goals, HFS restructured its Pay for Performance (P4P) and Pay for Reporting (P4R) program within managed care. These updated quality measures, aligned to the five pillars of improvement, are listed below.

Pillar: Adult Behavioral Health	
P4P:	• Follow-up After Hospitalization for Mental Illness (7-day and 30-day) • Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (7-day and 30-day)
P4R:	• Follow-up after High-Intensity Care for Substance Use Disorder (7-day and 30-day) • Pharmacotherapy for Opioid Use Disorder
Pillar: Child Behavioral Health	
P4P:	• Follow-up after Hospitalization for Mental Illness-ages 6-17 (7-day and 30-day) • Follow-up after Emergency Department Visit for Mental Illness-ages 6-17 (7-day and 30-day
P4R:	• Mobile Crisis Response Services that Result in Hospitalization • Visits to the Emergency Department for Behavioral Health Services that Result in Hospitalization • Overall Number and Length of Behavioral Health Hospitalizations • Number of Repeat Behavioral Health Hospitalizations
Pillar: Maternal and Child Health	
P4P:	• Prenatal and Postpartum Care (timeliness of care) • Childhood Immunization Status (combo 3)
P4R:	• Well-Child Visits in the First 30 months of Life • Child and Adolescent Well-Child Visits (ages 3-21) • Annual Dental Visits (ages 2-20) • Childhood Immunization Status (combo 10)
Pillar: Equity	
P4P:	• Breast Cancer Screening • Cervical Cancer Screening • Controlling High Blood Pressure • Adults' Access to Preventative/Ambulatory Health Services
P4R:	• Human Immunodeficiency Virus (HIV) Viral Load Suppression • Gap in HIV Medical Visits • Prescription of HIV Antiretroviral Therapy
Pillar: Community Based Services and Supports	
P4R:	• Long Term Services and Supports Comprehensive Care Plan and Update • Successful Transition After Long Term Care Stay

The Department monitors these measures to work with the MCOs on improving outcomes. To ensure health equity is maintained as a central focus, MCOs are required to report on the measures assigned to each pillar by race, ethnicity, gender, and preset zip codes. HFS meets with each MCO quarterly to review their specific data. At the quarterly meetings, MCOs are asked to review their outcomes, to

discuss any root cause analysis completed, and to discuss targeted interventions the MCOs have put in place related to improving outcomes. In addition, a quarterly quality meeting is held with all MCOs to go over general data outcomes and to allow guest speakers to discuss services available and best practices.

External Quality Review Organization (EQRO)

The Department contracts with an EQRO to perform external oversight, monitoring, and evaluation of the quality assurance component of managed care. Federal regulations at 42 CFR 438 requires that specific review activities by performed by the EQRO:

In accordance with 42 CFR 438.356, the EQRO conducts the mandatory and optional quality review activities as set forth in 42 CFR 438.358.

- Validation of performance measures;
- Compliance monitoring; and,
- Validation of performance improvement projects (PIPs).

The EQRO also conducts additional quality review activities on behalf of the Department. This includes an annual mandated review to assess the completeness of the Quality Strategy following the Centers for Medicare and Medicaid Services' (CMS) protocols. Review 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 Home and Community Based Service (HCBS) waiver participants);
- Overall Evaluation of the Quality Strategy;
- Technical Assistance on Quality Assurance Monitoring of MCOs
- A separate annual Consumer Assessment of Health Care Providers and Systems (CAHPS) survey for both the Medicaid and the CHIP programs which includes questions on children with chronic conditions.

Technology Transformation

Developing a state-of-the art technology platform continued in FY2023. 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:

- Illinois Medicaid Program Advanced Cloud Technology (IMPACT)
  - Phase I: Provider Enrollment System
  - Phase II: Medicaid Management Information System (MMIS)
- Integrated Eligibility System (IES) – Phases I & II
- Pharmacy Benefit Management System

While advancing towards full implementation of these technology milestones, HFS is working to ensure the new systems fully support the program changes that advance our Quality Pillars and reduce the programming time needed to achieve future goals.

Advancing Our Quality Pillars

- Adult Behavioral Health
- Child Behavioral Health
- Maternal and Child Health
- Equity
- Community-Based Services and Supports

CARE COORDINATION

CARE COORDINATION

HealthChoice Illinois

Illinois Department of Healthcare and Family Services

Managed Care Program Overview

The statewide Managed Care Program is a streamlined, accountable, and integrated program that strives to improve outcomes for customers consistent with the Department's program goals and mission of health equity, addressing social determinants of health, and advancing quality pillars. In FY2023, the Managed Care Program offered quality healthcare services and enhanced care coordination to upwards of 80% of all Medicaid customers. Ongoing collaborations between the Department, MCOs, and key stakeholders, including healthcare associations, hospitals, and other provides, continued to identify and drive improved program efficiencies.

Advancing Our Quality Pillars

- Equity

The Department's program works toward maintaining the highest standards of program integrity with equity as the foundation of quality improvement. During this reporting period, the Managed Care Program improved customer's lives by focusing on social and structural determinants of health, increased education, and outreach programs to empower customers to maximize their health and well-being. This is especially important in the first year "post-COVID." The Department also launched a second round of six Healthcare Transformation Collaboratives, bringing together key community partners and MCOs in key Disproportionately Impacted Areas (DIAs).

In managed care, MCOs must offer enrollees the same comprehensive set of services available to the FFS population, unless specifically excluded. These covered services include, but are not limited, to: hospital care, physician and specialist care, emergency care, laboratory and x-rays, mental health services, pharmacy, dental, vision, substance use disorder services, case management, transportation, and long-term services and supports (LTSS). All MCOs offer extra benefits to enrolled customers, above and beyond what is available under the FFS system. A chart comparing the extra benefits and services that health plans offer can be found on the Illinois Client Enrollment Services website at: ***https://enrollhfs.illinois.gov/en***

HFS operates three care coordination programs within the broader Illinois Medicaid Managed Care program: HealthChoice Illinois (HCI), YouthCare, and the Medicare Medicaid Alignment Initiative (MMAI).

HealthChoice Illinois (HCI)
In FY2023, the Department continued to contract with five (four statewide, plus one Cook County only) Managed Care plans to serve the HCI population, including:

- Families and children;
- ACA Adults;
- Seniors and adults with disabilities who are not eligible for Medicare;
- Dual Medicare-Medicaid eligible adults (dual eligibles) receiving certain LTSS, referred to as the MLTSS population;
- Special needs children, Former Youth in Care and Youth in Care; and,
- Effective January 1, 2024, adults and senior immigrants.

HCI offers a comprehensive set of benefits to all enrolled members. Additionally, HCI offers a specialized MLTSS program that provides customers with a combination of long term care (LTC), HCBS waiver services, care coordination, and some mental health and transportation services. All other services for MLTSS customers are covered by Medicare and the Medicaid FFS program.

HCI - YouthCare
YouthCare is a statewide, specialized MCO that provides services to DCFS Youth in Care and DCFS Former Youth in Care. ***Youth in Care*** are youth for whom DCFS has legal responsibility and includes youth living with foster parents, in group homes, or in residential settings. ***Former Youth in Care*** are youth who were previously in the care of DCFS and includes youth who have been adopted, are living with kinship providers, have returned to biological parents, and/or have left the DCFS system.

In FY2023, the program served over 36,000 youth and continued to focus on improving access to care for its members through active coordination and a robust provider network. YouthCare provides its members with additional benefits, such as trauma-informed care coordination for behavioral health needs, and provides specialized programs for adoptive families, including an adoption-competent network of therapists to support the different phases of adoption and child development. During this reporting period, the Department continued to work closely with DCFS, YouthCare, and various stakeholders to support program initiatives and workgroups to enhance the quality of care for DCFS youth.

Medicare/Medicaid Alignment Initiative (MMAI)
The MMAI three-way partnership between HFS, the CMS, and five MCOs continued to reform the way care is delivered to customers who are eligible for both Medicare and Medicaid services.

Dual eligible customers enrolled in MMAI receive the full range of covered services under the Medicare and Medicaid programs, including LTSS services. 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. Providers bill one MCO, regardless of whether the service is covered under Medicare, Medicaid, or both.

Customers can opt out of MMAI at any time, as well as re-enroll at any time. However, customers that receive services in a nursing facility or under one of the HCBS waivers and request to opt out of MMAI are required to participate in the HCI program under MLTSS.

On April 29, 2022, CMS issued a final rule for the Medicare Advantage (MA) and Part D programs, requiring states to convert all MMAIs to integrated dual eligible special needs plans (D–SNPs). As a result, and to maintain an integrated care option for dual eligible customers, Illinois will transition to D-SNPs effective January 1, 2026. Transition goals include:

1. Making sure D-SNP covers all Medicaid benefits to maintain a high level of care integration;
2. Minimizing disruptions in healthcare services and improving quality through improved customer experiences; and,
3. Increased customer and provider education and communications around the importance and benefits of the integrated care option.

Integration of services through MMAI has brought many gains to our customers. According to advocacy groups, it has helped customers make the most of their benefits, navigate the healthcare system effectively, and maintain greater independence in their communities. Integration has also strengthened community-based systems and eliminated cost-shifting between Medicare and

Medicaid. The Department is committed to maintaining the gains of this integration during the federally required transition from MMAI to D-SNPs.

MCO Program Information

HealthChoice Illinois (HCI) **Enrollees:** Children and their parents, ACA adults, seniors and persons with disabilities, special needs children, Youth in Care, former Youth in Care, and dual eligible adults age 21 and over, who receive LTSS and have opted out of MMAI. **Geographic Service Area:** Statewide **Mandatory Enrollment:** Yes	**Health Plans**	**June 2023 Enrollment**
	Aetna Better Health of Illinois	437,774
	Blue Cross Community Health Plans	787,804
	CountyCare Health Plan (Cook County only)	456,904
	MeridianHealth	905,453
	Molina Healthcare	357,831
	YouthCare	36,830
	Total HCI Health Plan Enrollment	**2,982,596**

Medicare-Medicaid Alignment Initiative (MMAI) **Enrollees:** Dual eligible adults age 21 and over who are eligible for both Medicare and Medicaid services and who have not opted out of MMAI. **Geographic Service Area:** Statewide **Mandatory Enrollment:** No	**Health Plans**	**June 2023 Enrollment**
	Aetna Better Health Inc.	16,324
	Blue Cross and Blue Shield of Illinois	22,735
	Humana Health Plan	16,515
	Meridian Complete Health Plan Inc.	17,794
	Molina Healthcare of Illinois	16,742
	Total MMAI Health Plan Enrollment	**90,110**

Total Managed Care Programs Participation	**Health Plans**	**June 2023 Enrollment**
HCI, MMAI	Aetna Better Health Inc.	454,098
HCI, MMAI	Blue Cross and Blue Shield of Illinois	810,539
HCI	CountyCare Health Plan	456,904
MMAI	Humana Health Plan	16,515
HCI, MMAI	Meridian Health Plan Inc.	960,077
HCI, MMAI	Molina Healthcare of Illinois Inc.	374,573
	Total Managed Care Programs Participation	**3,072,706**

Managed Care Quality Strategies, Programs and Care Coordination Activities

The strategies implemented in cooperation with the MCOs during FY2023 aligned with the Department's emphasis on equity and its Quality Strategy. The MCOs focused on improving equitable access and outcomes consistent with the Department's five quality pillars, encouraging opportunities for learning and collaboration with other agencies and community partners, and identifying resources for quality improvement activities.

Health Equity Efforts

Leadership within each MCO oversaw the strategic design, implementation, and evaluation of health equity efforts by:

- Making informed decisions around best payer practices related to health disparity reductions, including the provision of health equity and social determinant of health services and distribution of research to leadership and programmatic areas;
- Collaborating to ensure the MCO collects and meaningfully uses race, ethnicity, and language data to identify disparities; and,
- Ensuring that efforts addressed at improving health equity, reducing disparities, and improving cultural competence are designed collaboratively with other contracted MCOs to have a collective impact for the population, and ensuring that lessons learned are incorporated into future decision making.

All MCOs vigorously identified and developed initiatives to address health equity issues of special member populations. An example of this is as follows:

- An MCO identified a disparity in access to primary care visits for children diagnosed with behavioral health conditions living on the West Side of Chicago. The MCO observed behavioral health accounted for 74% of children with a healthcare claim for a chronic condition and that children with behavioral health conditions who are black (non-Hispanic) have lower rates of primary care usage than other children in West Chicago with behavioral health conditions; a likely factor impacting the lower-than-average high school graduation rates in West Chicago. The MCO identified opportunities to partner with Chicago Public Schools to expand the reach of behavioral healthcare through technology in that part of the city. The MCO also awarded a $200,000 grant to Lurie Children's Hospital to support a brand new, larger mobile health unit to address access to primary care and reduce no-show appointment rates. Both efforts will be evaluated by HFS through identified surveillance tool data elements.

Quarterly Business Reviews (QBRs)

The Department conducts a QBR with each MCO to review their health equity efforts and work related to the Quality Strategy. During the QBR, the MCOs define and describe their implemented strategies and detail how this work is moving health outcomes and care coordination efforts under each of the five pillars. The MCOs also review their analytics and data to support the strategies and related outcomes. One example of an innovative pilot discussed at the QBR is provided below:

- In FY2023, one MCO discussed the findings from a Diaper Bag Initiative with a Federally Qualified Health Center (FQHC) that focused on increasing postpartum visits. Care managers brought diaper bags to newborn visits, educating families on needed postpartum and newborn

care, and connected members to resources. This initiative resulted in a 15% increase in postpartum visits in 2023 at this FQHC compared to 2022. This MCO is currently exploring ways to expand this effort to other FQHCs.

Business Enterprise Program (BEP)

Annually, MCOs are contractually required to meet BEP subcontracting goals set as a percent of the administrative allowance included in total MCO capitation payments. Goals are set for minority-owned and female-owned businesses and for businesses owned by individuals with disabilities. In FY2023, all the MCOs exceeded their 20% goal for a total BEP spend of over $252 million.

The MCOs are proactively using BEP as a strategic pillar to support members that experience health inequities and barriers to health, specifically using vendors that help address food insecurity, transportation access or neighborhood safety, and other community resources. MCOs are also using BEP vendors in supply chains, outreach call center efforts, doula and other maternal health services, behavioral health telemedicine, and much more. All MCOs have developed expertise to identify potential BEP vendors and have helped vendors become BEP certified.

Health Equity and Social and Structural Determinants of Health (SSDOH) Workplans

The 2023 SSDOH workplans demonstrate the MCOs' commitment to advancing HFS' mission and the quality pillars. The workplans outline each MCO's plans of action and goals for the coming year, as well as describing how the MCO will identify, evaluate, and implement efforts to reduce health disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status. In developing and implementing workplans, housing was identified as a critical social risk factor. In response to this determination, many MCOs made significant investments and progress in addressing housing insecurity and homelessness among members. For example:

- One MCO has an innovative partnership between the City of Chicago and several community-based organizations. The program connects individuals who have experienced homelessness and are frequent users of crisis systems (e.g., emergency rooms, shelters, jail) to supportive housing and necessary stabilization services. Each participating member receives a multi-year commitment to cover housing costs, tenancy supports, and other interventions to integrate housing services with healthcare and care coordination.

HealthCare Transformation Collaboratives (HTC)

The HTC program encourages healthcare providers to partner together through the creation of collaboratives, with the goal of leveraging their shared resources and creating stronger, more innovative strategies to improve access, quality, and equity in their communities. In FY2023, the MCOs improved and deepened their coordination with the first round of HTCs to support the program's vision of expanding access to care for specific populations based on the needs of their communities. Specifically, coordination progressed in the areas of evaluation of specialized care coordination, data sharing, and the development of data sets, baseline metrics, and key performance indicators. The HTCs, in coordination with the MCOs, are focusing on services to address social determinant of health and access to needed clinical care in their communities. In some cases, MCO and HTC teams have actively engaged in joint case reviews to identify all needs and strategize on interventions of each member of the HTC's target population.

While MCOs will be better positioned to evaluate the impact of their HTC partnerships in FY2024, some partnerships are already having an impact – one MCO has seen a 5% reduction in Emergency Room (ER) visits and a 6% reduction in inpatient admits per 1,000 members between FY2022 and FY2023. Some HTCs had individual reductions of 12% (ER) and 10% (inpatient admits) for one MCO.

During FY2023, the Department moved forward with 6 additional HTCs, bringing the total number of collaboratives statewide to 15. These HTCs, in coordination with the MCOs, are focused on improving maternal and child health throughout Illinois, reducing health disparities among older adults on the south side of Chicago, and expanding behavioral health offerings for youth on the south and west sides of Chicago.

Community Transition Initiatives (CTI)

Through CTI, MCOs may receive incentive payments for the successful transition of interested and eligible members living in Cook County Nursing Facilities (NF's) and statewide Specialized Mental Health Rehabilitation Facilities (SMHRFs) into the community, with a particular emphasis on community transitions for **Williams and Colbert Class Members**.

This initiative supports improvements in the quality pillar focused on serving more people in the settings of their choice. During FY2023, the MCOs focused on transitioning Williams and Colbert Class Members into the most integrated community-based setting appropriate to promote each member's independence in daily living, economic self-sufficiency, and to allow them to interact with persons without disabilities, to the fullest extent possible.

The Department provides reimbursement to MCOs for the use of Transition Assistance Funds (TAF), which allows MCOs to pay for things that assist their members in transitioning to the community, such as housing application fees, furniture, bedding, and household essentials. Bridge Housing Subsidies are also available to help ensure a successful transition for Williams and Colbert Class members. To maximize opportunities for a successful transition to the community, MCOs also provide their members with help applying for SSI/Social Security Disability Insurance (SSDI) benefits, linkages to employment, financial counseling, food and nutrition services and counseling, ongoing care coordination, homemaker services, and more.

MCO Marketing, Outreach and Education Plans (MOEP)

The MOEPs identify the MCO's annual outreach and community engagement strategies and describe how these efforts will contribute to improved quality of care, access to care, and performance outcomes for members. The FY2023 MOEP strategies focused on:

- Increasing customer self-care management, including promoting primary care provider selection to encourage preventative care and appropriate health screenings.
- Equity-focused education and outreach initiatives focused on adults that are designed to improve chronic disease management and behavioral health through health literacy and lifestyle programs.
- Education and outreach initiatives on maternal and child healthcare.
- Education and outreach initiatives on behavioral health, including reducing barriers to diagnosis and care for all populations.

- Increasing enrollment and redeterminations for hard to reach populations.
- Educating and increasing awareness of members and potential members in a community centric manner.

Care Coordination

MCO care coordination activities aim to help their members find the right care based on their health needs and to manage health conditions like diabetes, high blood pressure and asthma. In FY2023, the MCOs actively promoted necessary and timely vaccinations and boosters and offered ongoing education efforts among members through text messaging, community outreach events, email and phone campaigns, social media, education videos, and print materials. MCO staff assisted members with promoting healthy lifestyles, setting health goals, sharing tools and information to help meet those goals, making appointments for routine wellness visits, arranging transportation, partnering with provider and community groups to promote events and access to community resources (e.g., food pantries, support groups), and transitioning members from inpatient settings back into their home or community. MCOs have specialized care coordination teams for community support, pregnant mothers, substance use disorders (SUD), mental health, HCBS waivers, and more. Examples of MCO care coordination activities and outcomes in FY2023 are:

- **Pregnant Mothers -** One MCO's care coordination team seamlessly synchronized behavioral and maternal healthcare for a pregnant mom in metro east Illinois. The member had an extensive history of anxiety and depression, had stopped taking her medication after becoming pregnant and was not keeping up with medical or behavioral health appointments. The care coordination team was able to educate and encourage her to re-engage with providers. After delivering a healthy baby, the MCO staff worked with providers and helped aid in the process of her resuming behavioral health medications. A key intervention was to help tag-team her obstetrician-gynecologist (OBGYN) and behavioral health appointments to ensure compliance with appointments and treatment plans. Ensuring transportation helped the member attend all her appointments.
- **SUD -** MCO efforts have shown to save lives through the use of tools to monitor controlled substance use and combat drug seeking behaviors by assigning members to one provider and pharmacy along with care coordination. In addition, some MCOs have embedded staff at key community-based providers to work with members suffering from a substance use disorder to assist with appropriate care planning.
- **Best Practices -** One MCO made permanent a Member Care Fund to address social determinants of health and improve health outcomes. It was designed as a care coordination tool to provide otherwise unavailable resources/services to help high and moderate risk members overcome barriers and fill gaps identified through assessment, individual plan of cares, and integrated care team (ICT) meetings. The member's care coordinator identifies a need and possible solution along with clinical rationale supporting how/why the solution will impact the member's health. A committee then evaluates the request and if approved, the requested item/service is sent to the member to fill the identified gap. In the first half of FY2023, the program served over 1,000 unique members; average spending per person was $141 with a 3:1 return on investment. Eligible requests may include application fees, basic health care items not covered by insurance like shower mats or bath chairs to prevent falls, clothing, cell phones, deep cleaning when homemaker services are in jeopardy of being discontinued, emergency housing, hygiene items, wellness items, and/or housing or household items. A few Member Care Fund success stories are included below:

- Items recommended by an applied behavior analysis (ABA) provider were purchased to help to de-escalate a teenager with behavioral health needs. Items included things such as a chair for his room, a music streaming service, and wireless headphones the family could not afford. The ABA provider taught the family and support workers how to use the items to help the member, allowing the family to create a safe environment and reduce the likelihood of future ER visits and admissions.
- The first 30 days at a sober living community were paid on behalf of a member. During that time, the care coordinator worked with the facility to find the member a full-time job to allow him to continue to pay for his stay. While there, he remained sober, attended AA meetings, and addressed his physical and behavioral health needs and remains engaged in care coordination.
- A member experiencing homelessness had at least one admission per week to a behavioral health acute care hospital. The Member Care Fund was used to provide basic clothing and a phone to promote stability for the member to engage with his community support team that helped him gain housing through the DHS Front Door Diversion Program. He no longer sought admission to the behavioral health Acute Care hospital.

Redetermination/Renewal Strategies

The COVID-19 PHE came to an end in FY2023, resulting in Congress establishing an end to continuous Medicaid coverage for customers. The MCOs became an integral part of the Department's strategy to ensure customers received important information during this unwinding period, critically working to secure current contact information (updated addresses and emails) for ongoing customer communications, including informing customers of their Medicaid eligibility redetermination date. MCOs reported thousands of updated addresses to HFS through monthly reports, as well as assisted members with updating addresses directly within the ABE portal.

The MCOs also supported Illinois' "Ready to Renew" campaign. Using HFS provided data, MCOs established strategies to: identify and locate hard to reach members; target outreach to Medicaid customers due for renewal; partner with community health workers, community-based organizations, and providers; host events; and assist customers who would lose coverage either submit information for reinstatement into Medicaid or transition to low-cost marketplace coverage.

As a result of these efforts, federal data shows that Illinois has the highest Medicaid renewal rate among states midway through unwinding from pandemic-era continuous coverage. The impact of the MCOs' efforts is reflected in the difference between renewal rates of MCO enrolled customers and those enrolled in FFS Medicaid. For October 2023, while both were tremendous, MCO members had redetermination response rates above 87%, while FFS response rates were at 75%.

Consumer Report Cards

As part of its Managed Care Program customer education and enrollment assistance process, HFS continued to apply and publish the HCI Consumer Report Card (Report Card). The Report Card is a customer quality comparison tool that reflects the performance of the HCI program by comparing the MCOs across key performance areas which align with HFS' goals and pillar-focused population streams. The six performance areas included in the Report Cards are:

1. Doctors' communication
2. Access to care
3. Women's health
4. Living with illness
5. Behavioral health
6. Keeping kids healthy

Each MCO is assigned up to five stars to indicate how it performs relative to other MCOs on each measure. The information used to create the Report Card is collected from the MCOs and their members and is reviewed for accuracy by the EQRO annually. Samples of the HCI Consumer Report Cards are found here: ***https://enrollhfs.illinois.gov/en/healthchoice-illinois***.

Admission, Discharge and Transfer (ADT) System

Through the ADT system, MCOs receive real-time notifications and data on their members, including notifications for when a member is admitted to a hospital or ER and discharged or transferred from the hospital or NF. ADT data allows for updates four times a day into the MCO's provider portals for providers and the MCOs to access real-time status changes. The data sharing helps accelerate member engagement, allowing care coordinators and providers to outreach and arrange follow-up care after discharge. Access to this information by the MCOs helped them to:

- Identify members with behavioral health inpatient utilization to better facilitate discharge planning and promote timely post-discharge follow-up, advancing the adult and child behavioral health quality pillars.
- Develop customized Reports to provide specific utilization insights for specialized populations like behavioral health so that MCO care coordinators can work with members to, among other things, reduce ER visits.

One MCO saw a reduction in ER visits per 1,000 members from 679 to 591 between 2022 and 2023. Members in care management using ADT data experienced a 9% decrease in ED visits between May 2022 and May 2023.

Managed Care Program Reimbursement

HCI Capitation Rates

MCOs are reimbursed through capitation rates which the federal government must approve. Capitation rates are a fixed amount of money, referred to as per member per month (PMPM) payments, which the Department pays monthly for the MCOs to assume full responsibility or risk for providing customers with healthcare services. The rates are developed based on encounter claims from the MCOs that are validated by HFS' consulting actuaries. Adjustments are made for healthcare management, trends, program changes, and MCO administration. All capitation rates must be actuarially sound per federal regulations (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 the Department determines to be actuarially significant.

MMAI Capitation Rates

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 HFS 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 (NF, HCBS waiver, or community). It includes an LTSS blended rate based on the NF and HCBS waiver enrollment mix in each MCO at the beginning of the calendar year. The NF portion of the blended LTSS rate is risk adjusted.

Directed and Pass-through Payments

Under CMS-approved directed payment programs and pass-through payments (42 CFR 438.6), the Department disburses funds to MCOs to issue direct payments to providers. The Department provides the MCOs with specific instructions each time such funds are disbursed to identify the amount the MCO is to issue to each eligible provider, and the timeframe in which the payment should be made.

Pay for Performance (P4P) and Reporting (P4R)

In addition to capitation rates, the HCI contracts include P4P measures, selected to align with HFS' five quality pillars, to incentivize spending on care that will increase 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 set performance measure benchmarks. Under the MMAI contracts, both Medicare and Medicaid also withhold a percentage of their respective components of the capitation rate. MMAI MCOs can earn back their withholds if the MCO meets or exceeds performance on a combination of core quality withhold measures across all demonstrations nationally as well as Illinois-specific quality withhold measures.

During the reporting period, HFS continued to build on its modified P4P framework so that MCOs continued to reinvest in strategies with a focus on the five quality pillars. This framework not only included equity but also greatly impacted organizations and providers that were not already receiving

other support. Customer-centered efforts led to positive outcomes across the state, including in DIAs, by increasing in care coordination and health services, increasing community engagement, and expanding access to food pantries and health rewards programs.

Medical Loss Ratio (MLR)

MLR means an MCO must utilize a defined percentage of its capitation rates for healthcare services, quality improvement, and administrative costs. Under HCI, the MLR was 88% (a minimum of 88% must be spent on healthcare services and quality improvements and a maximum of 12% may be spent on administrative costs).

Ongoing Health Plan Investments Customer Impacts

During FY2023, as MCOs focused on the equity pillar they continued to invest in critical services and initiatives to help Medicaid customers and providers. MCOs invested by increasing reimbursement rates for behavioral health providers, expanding telehealth capabilities and infrastructure, increasing community engagement in Black, Brown, and Latin communities by contracting with BEP organizations, providing technology assistance, extending housing benefits; and continuing to provide food and funding to school-based health centers.

- For example, several MCOs partnered with community gardens that produce food sold at local farmers' markets. MCO members who participated received vouchers to buy fresh, healthy produce. Several MCOs also partnered with Sweet Potato Patch to provide home delivered, healthy food to pregnant moms and their families, so moms don't have to decide whether to eat themselves or feed their children.

Value-Based Payments (VBP)

By tying financial incentives to performance to advance the goals of the quality pillars, the MCOs' VBP plans included a wide range of provider payment strategies meant to improve healthcare quality, outcomes, and efficiency.

All MCOs implement P4P programs broadly across their networks as a foundation of the VBP approach, with a particular focus on quality measures that align with HFS' Quality Strategy.

- One MCO was the most advanced in terms of implementing higher level Alternative Payment Models (APMs) that feature downside risk and full risk.
- Three of the MCOs have expanded participation in VBP arrangements featuring downside risk.
- One MCO did not have any spend in a VBP arrangement with downside risk.

All MCOs reported higher quality performance and gap closures among providers participating in the Quality Improvement Program.

- One MCO reported that providers in downside risk arrangements realized a Medical Loss Ratio that was 8% lower than the plan average and a 4% higher quality gap closure rate. In addition, six of the seven provider groups reduced ED visits per 1000 members with an average reduction of 39% and reduced Inpatient visits per 1000 members with an average reduction of 77%. All seven provider groups in down-side risk arrangements reduced ED spend with an average reduction of 67%.

Supports for Providers

HFS continued to support providers in successfully navigating the Managed Care Program and encouraging communication between providers and the MCOs in FY2023. In collaboration with the MCOs, HFS has persisted in offering a range of provider supports intended to streamline administrative processes amongst MCOs whenever practical and give providers a forum to discuss and resolve any issues they may be experiencing with the MCOs. Four such examples are listed below.

- **Comprehensive Billing Manual for Providers** - Developed collaboratively between the MCOs, the Illinois Association of Medicaid Health Plans (IAMHP), and the Department, the Comprehensive Billing Manual proved to continuously assist most Medicaid enrolled provider types with Managed Care Program with billing questions during FY2023. In a single source, the manual compiles all MCO claiming policies and procedures for ease of provider reference, leading to an improvement in provider relations and reduction in provider claims denials. The billing manual is frequently updated to reflect changes within billing policies and procedures as they are implemented. HFS also issues Provider Notices with a summary of changes whenever updates to the IAMHP billing manual are published. The Comprehensive Billing Manual is maintained on the IAMHP website: ***https://www.iamhp.org/.***

- **Provider Resolution (Complaint) Portal** - Providers who are unable to settle their disputes with an MCO directly can submit a complaint with HFS through the secure; ***online MCO Provider Resolution Complaint Portal***. The portal encourages communication between the MCO and provider and is a tool that ensures fair resolution of disputes in an electronic and secure format. Provider complaints submitted via the portal are processed under the provider dispute resolution process and must adhere to applicable timeframes as required by Public Act 101-0209. MCOs have 30 calendar days from the time the complaint is submitted to the portal to investigate and provide a written proposal for resolving the disputed complaint ticket. MCOs who fail to provide prompt portal resolution responses for complaints are subject to sanctions. The MCOs received no sanctions in 2023 for untimely proposal responses. Copies of sanction letters issued to the MCOs are posted on the Department's Care Coordination Page: ***https://hfs.illinois.gov/medicalproviders/cc/sanctions.html***.

- **MCO-Provider Accountability Meetings** - HFS continued to promote relationship building and the successful resolution of disputes between providers and MCOs through the facilitation of regular joint meetings. The joint meetings include representation from HFS, IAMHP, the MCOs, and various Medicaid provider groups participating in Managed Care Programs. Discussions conducted during these meetings offered an opportunity for providers and MCOs to work together in identifying issues that may be impacting multiple areas of the provider networks. These meetings also provided a platform that aimed to improve care coordination and quality in the managed care programs with focus on the five pillars. In FY2023, HFS conducted joint meetings monthly and discussions continued to shift from billing/claiming issues to joint accountability.

- **Advance Communication Engine (ACE)** - ACE captures pre-adjudicated claims from billing providers, such as hospitals, and remittance advice (claim payment/denials) in real-time from the MCOs. The purpose of ACE is to streamline the billing process, enhance the claims payment rate for Medicaid billing providers, and improve care coordination services for all

managed care members. HFS and the MCOs are still working on drill-down capabilities within the ACE dashboard to analyze data by MCO and by provider name, provider type, Safety-Net Hospitals, and behavioral health facilities. Furthermore, data collection in the ACE dashboard is ongoing to eventually determine and report on the top ten reject/denial reasons and top ten reject/denial providers.

What's Ahead for Managed Care?

During FY2024, the Department will continue to strive to achieve the highest standards of Managed Care Program integrity, will center equity as the ongoing foundation of quality improvement, will work to demonstrate steady improvements in customer's lives through continued focus on social and structural determinants of health, and will offer education and outreach programs to empower customers to maximize their health and well-being.

LONG TERM SERVICES & SUPPORTS

LONG TERM SERVICES & SUPPORTS

This section provides an overview of the following components of the LTSS program administered by the Department: Institutional, 1915(c) HCBS waivers, and other community programs. For more information, please visit: ***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 customers, meet standards of quality, and are compliant with federal and state regulations. This section gives basic information about the LTC program and provides a more detailed summary of nursing facilities, which are overseen by both HFS and DPH.

There are four basic types of institutional settings in the LTC program: Nursing Facilities (NF), Specialized Mental Health Rehabilitation Facilities (SMHRFs), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and Medically Complex for the Developmentally Disabled (MC/DD).

Number of Facilities & Number of Beneficiaries Served

Nursing Facilities (NF):
- 671 NF
- Averaged 46,923 customers served in FY2023

Specialized Mental Health Rehabilitation Facilities (SMHRFs)
- 22 SMHRFs
- Averaged 2,995 customers served in FY2023

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)
- 192 ICF/IIDs
- Averaged 3,472 customers served in FY2023

Medically Complex for the Developmentally Disabled Facilities (MC/DD)
- 10 MC/DDs
- Averaged 815 customers served in FY2023

Licensed & Medicaid Certified LTC Beds

Fiscal Year 2023 Actual

Level of Care	Medicaid Certified Beds[1]	Licensed Beds[2]
Skilled Care	71,115	77,582
Specialized Mental Health Rehabilitation Facilities (SMHRFs)	0	3,923
Intermediate Care (ICF)	8,526	8,658
Intermediate Care for Individuals with Intellectual Disabilities	3,972	3,972
Skilled Care for Individuals with Intellectual Disabilities	1,168	1,168
Total	**84,781**	**95,303**

[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.

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.

The NF assessment program was restructured effective July 1, 2022. The $1.50 assessment on licensed beds days was terminated, while the assessment on non-Medicare occupied bed days was revised from a uniform tax of $6.07 to a tax that varies based on the provider's volume of Medicaid days. In the first FY of the new assessment, it has nearly doubled the assessment collections as well as the federal revenues to support NF payment reforms.

Funds generated by the Program are set forth below:

Fiscal Year	Nursing Facilities	ICF/IIDs
2020	$168.7	$18.3
2021	$162.6	$20.2
2022	$160.6	$20.7
2023	$302.3	$20.8

**Dollars in millions*

Nursing Facilities

The Department has numerous responsibilities for NFs, including responsibility for developing NF policy in accordance with state and federal regulations, enrolling providers, and ensuring that sanctions set by DPH 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-payment and post-payment review adjustments, providing billing assistance and information to providers, resolving billing discrepancies, and coordinating admissions information entry with DHS. HFS further determines whether NFs meet the federal definition of an Institution for Mental Diseases (IMD) for federal Medicaid claiming purposes.

Nursing Facility Reimbursement

Under the FFS 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 the NF's case mix (average resident needs and service provided to each resident within the NF) and reforms highlighted below.

After over two years of research, analysis and collaboration with industry stakeholders, HFS implemented reforms to the nursing (direct care) reimbursement component effective July 1, 2022. Utilizing increased funding from the revised assessment tax, as well as additional state funding, the following changes were made to improve payment accuracy and integrity, incentivize higher staffing levels and improve the quality of life for residents:

- The Patient Driven Payment Model (PDPM) case mix classification system was adopted as the basis for calculation of the direct care rate, replacing use of the Resource Utilization Groups (RUGs) methodology.
- The base per diem amount for direct care was increased by $7/day to $92/day - to account for wage increases.
- A tiered per diem add-on was created to incentive higher staffing levels, ranging from $9/day to over $38/day.
- A Quality Incentive Payment program was established to distribute $70 million annually based upon Medicare Long Stay Star ratings.
- Providers who implement compliant CNA wage scale retention and promotion increases will be reimbursed for the Medicaid portion of the increases up to $6.50/hour for experience and $1.50/hour for promotions.
- Providers whose resident population is at least 70% Medicaid will receive an additional $4/day Medicaid Access add-on to the per diem rate.

Under ***89 Ill. Adm. Code 153.100***, nursing, support, and capital rate components are also based on changes unique to a NF:

- 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;
- 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 59 facilities in FY2023;
- 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 one (1) NFs.

Certification/Decertification of LTC Facilities

During FY2023, Eleven NFs closed. Four closed due to financial hardship, four voluntarily closed and three closed due to staffing issues. One NF enrolled in the Medical Assistance Program during this same period.

NF Rate Reform - Implemented July 1, 2022

On May 31, 2022, Governor Pritzker signed HB0246 (PA 102-1035) into law, ushering in historic Medicaid nursing home payment reforms that more closely align reimbursement with resident needs and quality of care. The new payment methodology included a revised nursing home assessment, a shift to the federal PDPM to reflect residents' care needs more accurately, and new funding tied to staffing and quality measures.

The new law was intended to improve transparency, accountability, and health equity, particularly for NFs serving higher percentages of Medicaid residents. The reform also sought to achieve some key goals that directly impact the lives of Medicaid customers receiving care in Illinois NFs, including:

- Increasing nursing facility funding to account for rising labor costs;
- Tying funding to nursing facility performance, including both staffing and quality;
- Redistributing funds according to a more accurate measure of resident care needs (PDPM);
- Eliminating the current incentive for facilities to code higher levels of care needs than their nurse staffing levels indicate;
- Reducing inequities in staffing and quality among the state's low-income, Medicaid and racial and ethnic minority NF populations;
- Providing a viable path towards improvement for Illinois' lowest-performing NFs, and,
- Enhancing reporting requirements to achieve full transparency into individual-level ownership of NFs.

The 2022 reform increased nursing facility reimbursement by $704 million in FY2023 and $666 million in future years. This is an increase of 27% in FY2023 (25% ongoing) over the total FY2022

nursing facility reimbursement. Funding of the non-federal share of this increase was made through a combination of state GRF and an increase in the NF provider assessment. The reimbursement increases were implemented through a combination of per diem rate increases and the addition of new supplemental payments. These reimbursement increases were intended to incentivize NFs to increase nursing staff, particularly CNA staff. The reimbursement increases were also intended to encourage NFs to improve the quality of care provided to Medicaid residents.

New Nursing Home Assessment

The 2022 rate reform streamlined and increased the nursing home bed tax from a two-pronged tax comprised of $6.07 per occupied bed day plus $1.50 per licensed bed to a single tax with a variable rate based on Medicaid resident days. The reform package resulted in an increase of the state's taxing authority to (very nearly) the federal maximum of 6% of total revenue. The assessment was projected to inject approximately $208 million in additional revenue for NF reimbursement in FY2023 to help fund the staffing and quality initiatives outlined below. HFS estimated the combination of new and redirected payments with the streamlined assessment would improve cost coverage for facilities at every level of Medicaid utilization, but that the highest Medicaid facilities would gain the most.

Transition to Patient Driven Payment Model

The legislation stipulated a transition to the PDPM case mix methodology beginning in FY2023, to be implemented in a gradual fashion over the course of five quarters. For the quarter starting on July 1, 2022, each NF's rate was calculated using the higher of either the PDPM or a blended PDPM/RUG case mix rate. For successive quarters the blended rate was progressively shifted to a full PDPM rate. Individual facility rates were calculated based on either the blended rate or 100% PDPM, whichever was greater. According to this schedule, by the quarter starting October 1, 2023, rates were fully transitioned to the PDPM system.

The transition to PDPM was intended to improve payment accuracy and appropriateness by shifting case mix (and payment) away from rehabilitation services (which are most often paid by Medicare rather than Medicaid) toward true resident need. The intent was to direct Medicaid base payments for nursing care to facilities in proportion to the documented need for Medicaid-financed care in that facility. Moving to PDPM was predicted to reduce overall variation in payment rates across facilities by addressing the distorted case mix index (CMI) and rate inflation found in the RUG system.

Staffing Add-On Payments

One of the most important goals of the 2022 reform was to directly link rates to improved staffing levels. Previous rate increases that were intended to support staffing improvement, but were not tied directly to it, did not have any notable impact on staffing levels. Before the 2022 reform, staffing levels in Illinois NFs ranked consistently as the lowest in the nation, and with facilities having the highest percentage of residents of color showing the lowest levels. As a result, the reform legislation explicitly tied reimbursement to staffing levels. A new add-on payment is now included in the rate calculation based on a facility's Staff Time and Resource Intensity Verification (STRIVE) staffing level, and ranges from $9 for facilities at 70% of the STRIVE target to a high of $38.68 for facilities with staffing of at 125% of the STRIVE target. The add-on is intended to reward facilities with sufficient and sustained levels of staffing, while still providing support and incentive for lower staffed facilities to

invest in new staff. This incentive accounted for approximately half of the 2022 reform package and may now constitute the largest nursing facility staffing-related incentive in the country, inclusive of the Medicare program (excluding cost reimbursement schemes). A transition period was incorporated guaranteeing an add-on from July through December 2022 equal to no less than the amount earned for staffing at 85% of the STRIVE target (i.e., $18.59 per resident day) – or higher if staffing levels were above 85%.

CNA Staffing, Wages, and Retention

In the ongoing effort to enhance the quality of care in NFs across Illinois, the state introduced a directed payment system specifically targeting increased wages for CNAs. Historically, CNAs have played a pivotal role in the day-to-day care of NF residents, often serving as the primary caregivers and the frontline of resident interaction. However, despite their critical role, CNA compensation had not reflected the importance and demands of their work. Recognizing this discrepancy, HFS' 2021 report recommended a Medicaid-subsidized experience and promotion pay scale incentive program for CNAs.

The intended impact of the CNA experience and promotion pay scale incentive program was multifaceted. During the COVID-19 PHE, the CNA workforce shortage was often associated with high turnover and short CNA tenures and was thus perceived to be the result of a shortage of training programs and the need to increase the number of CNAs entering the workforce. Pandemic-era recruitment strategies were punctuated with well-advertised and sometimes very large signing bonuses. However, given the limited number of training slots available, HFS calculated the vast majority of working CNAs must have had at least one year of experience. In addition, available evidence suggested that CNA pay scales were flat, with average pay just above minimum wage. To protect the remaining CNA workforce and begin to address the shortage thus required a strategy focused on those CNAs who had left, or might leave, the profession, more so than strategies focused (solely) on those who might enter it.

By enhancing the compensation of experienced CNAs and allowing the market to determine the overall level of pay (e.g., starting pay), the state aimed to significantly reduce the high turnover rates that were believed to characterize the industry. During the COVID-19 PHE, as the demand for CNA staffing gradually returned and the number of practicing CNAs went down, a common narrative among NF owners was the flight of employed CNAs to temporary employment agencies where they could receive higher wages, but with no promise that these higher wages would be maintained.

The CNA pay scale subsidies were intended to play a crucial role in recasting the economic profile of employed CNAs going forward, using Medicaid's buying power to coordinate permanent wage increases at a more sustainable level of remuneration across the NF industry. The minimum pay scale required for NFs to receive this subsidy rewards long-serving CNAs the most and in amounts that meaningfully improve these critical workers' economic status. By making the profession itself more financially attractive, the hope was to expand the pool of available CNAs by retaining existing CNAs and attracting new entrants to the field based on their expectation of future pay

Quality of Care

In addition to improving the quality of care by stabilizing and improving the staffing and tenure of CNAs, the state recognized the need to provide a direct financial reward for high quality NF care.

Beginning in July 2022, the state established a $70M quality pool and implemented a directed payment system specifically tied to the quality of care within NFs. Each NF is assigned a weighted quality score calculated using CMS' composite long-term stay Star quality measure. Selection of the long-stay metric versus other CMS metrics reflected Medicaid's dominant role in financing extended NF stays. Quarterly bonus payments are made based on long-stay Star scores using proportional values adopted in the 2022 reform legislation. This competitive mechanism was designed to incentivize facilities to prioritize and invest in measures that directly enhance the quality of care.

A much more detailed write-up on the rate reform process can be accessed on the HFS website at: ***Interim Review of the 2022 Nursing Home Payment Reforms.***

Eligibility Processing

Public Act 98-0104 requires HFS and DHS to:

- ***Complete LTC eligibility determinations in a timely manner.***
  DHS has continued their focus on LTC case processing and continual training. The fourth LTC hub in Anna was created on January 16, 2021. Both the LTC processing unit in Granite City and the office in Anna continue to process applications and work on special projects. All the DHS LTC offices contain specifically trained caseworkers to handle LTC processing of applications, admissions, redeterminations, and changes. Additionally, all the DHS offices have moved from "task-based" to "facility-based" assignments. This change is intended to increase productivity and more evenly distribute workflow. HFS and DHS continue to utilize a database of pending LTC applications and admissions to ensure tasks are tracked based on age and status.
  The Department started automatic processing of transfer admissions in March 2020. This combination of efforts and the work of DHS management and staff have reduced the number of admissions pending more than 45 days from over 11,000 at the end of 2019 to 519 by the end of December 2022. Applications pending with the HFS Office of Inspector General (OIG) for resource review were 121 at the end of December 2022. Work continues to focus on systematic and operational 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 IES.***

  The Department 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 ABE. The ABE partner portal continues to be a great resource for providers by offering an additional avenue for providers to upload redeterminations and verifications directly to a customer's case. Several updates have been made to IES, which has improved application processing. Updates continue to IES and ABE to better serve customers and providers.
- ***Develop and implement a streamlined LTC application process.***

  HFS and DHS representatives meet regularly to identify ways to streamline the application process. Training sessions on using the ABE application system and the provider portal were videotaped for use as webinars on the 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 customer to prove eligibility. Including AVS, which is an electronic asset verification system. Some information is not available from current electronic sources and must be requested from the applicant.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is designed to offer comprehensive health services for seniors living in the community who would otherwise qualify to live in a NF. PACE creates a new model of community-based, comprehensive care in Illinois that will give seniors an additional choice in how they access healthcare as needs change with age, allowing more seniors to continue living at home safely, for longer. PACE will put in place an integrated model of care that is specific to each senior, and this level of customization will improve health outcomes not just for the seniors who enroll, but for the overall community.

A PACE organization is responsible for providing care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year. Services must be furnished in the PACE center, the home, and inpatient facilities, up to and including admission to an acute care or LTC facility when the PACE program can no longer support the customer safely in the community. The PACE center includes a primary care clinic and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and serves as the focal point for coordination and provision of most PACE services.

Illinois' Vision for PACE

The goals of PACE are to:

- Improve health and wellness for qualifying individuals by expanding the LTC service continuum;
- Customize solutions to meet the unique needs of communities, beginning in five DIAs of the state;
- Support healthcare delivery models that improve outcomes, decrease disparities, and are sustainable over time; and,
- Align the PACE program strategy with the Department's other healthcare transformation initiatives.

Four of the selected eight PACE organizations have submitted their application to CMS and anticipate receiving their Program Agreement allowing them to begin enrollment during the summer of 2024. Additional information on PACE can be found at:
https://hfs.illinois.gov/medicalproviders/pace.html

Preadmission Screening and Resident Review (PASRR)

The PASRR process requires that all applicants to Medicaid-certified NFs be given a preadmission, preliminary assessment to determine whether they might have a Serious Mental Illness (SMI), an Intellectual Disability (ID), or a Developmental Disability (DD), and then fully evaluated in the event the screening indicates potential presence of one or both conditions. Additionally, it requires that admitting facilities provide the services identified as necessary in the evaluation.

PASRR is an important tool for states to use in rebalancing services away from NF and towards supporting people in their homes, and for complying with the Supreme Court decision, Olmstead vs

L.C. (1999), under the Americans with Disabilities Act. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care.

In March 2022, the Department and its contracted partner (Maximus), DHS-DDD, the DHS Division of Mental Health (DMH), and the DOA implemented an improved process for preadmission screenings for individuals seeking LTSS through an institutional setting. With Maximus' AssessmentPro platform, great strides have taken place to ensure timeliness, accuracy, consistency and a more streamlined process to complete required screenings (known as Level I) and assessments (known as Level II) for individuals who may have SMI, ID, or DD.

The redesign also included the development and implementation of specialized assessments for individuals seeking admission to SMHRFs and Supportive Living Programs (SLPs) to ensure admission to these settings are the most appropriate and aligned with the individual's needs and preferences. Under this redesign, individuals found eligible to admit to a SMHRF are offered referral to the DHS-DMH Front Door Diversion program.

The implementation of this new process and assessments has allowed Illinois to decrease the turnaround time to complete this assessment, connect individuals with LTSS more quickly, and improve ongoing care coordination efforts.

HCBS Waivers

Advancing Our Quality Pillars

Community-Based Services and Supports

In an effort to support independence and promote the health, safety and welfare of customers in their homes, the Department, in collaboration with DOA, DHS, and DSCC, offers LTSS through nine HCBS waiver programs. These waivers provide alternatives to NF placement for customers, allowing them to remain independent in their homes or community settings. The nine HCBS waivers served 136,154 people in FY2023. The Department, in its role as the single state Medicaid agency, provides administrative coordination, direction, oversight, program, fiscal, and quality monitoring for all nine waivers.

HCBS waivers, authorized under 1915(c) of the SSA, allow states to provide specialized LTSS to customers 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.

During the COVID-19 PHE, CMS allowed states to offer additional waiver services and flexibilities through the approval of Appendix K waiver amendments. In FY2023, the Department began implementing unwinding activities for HCBS waiver services and is actively working to make some of the Appendix K flexibilities permanent after the PHE ends.

To enhance financial accountability and comply with a federal mandate of The 21st Century Cures Act, the Department also began implementation of Electronic Visit Verification (EVV) for Adults with Developmental Disabilities and the Support Waiver for Children and Young Adults with Developmental Disabilities for Personal Care Service (PCS) on September 1, 2023. EVV for home health care

service (HHCS) providers was implemented on December 31, 2023. EVV promotes quality services, ensures customers receive authorized services, and improves program integrity through the following objectives:

- Reducing overpayments and claiming errors;
- Safeguarding against waste, fraud, abuse, inefficiency, and duplication;
- Improving oversight of provider performance, beneficiary access, care coordination and transitions, and program expenditures and utilization;
- Developing a system that will accommodate limited internet access in rural areas;
- Ensuring compliance with approved person-centered plans and prior authorizations; and
- Monitoring the receipt, timeliness, and completeness of authorized Medicaid home-based services.

The DHS Division of Rehabilitation Services (DRS) and the DOA already had an active EVV system in place prior to the implementation in the DHS-DDD waivers. In the future, the state's EVV will begin to aggregate the data from the various EVV solutions for all the waivers to serve as a central source of data in continuing efforts to improve service delivery, quality outcomes and oversight.

All but the SLP waiver are operated by non-HFS state agencies through interagency agreements (IGAs). Each HCBS waiver is designed for individuals with similar needs and offers a different set of services. The HCBS waivers and the operating agencies are outlined below:

Waiver	Operating Agency
Persons with HIV or AIDS	DHS-DRS
Persons with Brain Injuries	DHS-DRS
Persons with Disabilities	DHS-DRS
Adults with DD	DHS-DDD
Children and Young Adults with DD - Support	DHS-DDD
Children and Young Adults with DD - Residential	DHS-DDD
Persons who are Elderly	DOA
Medically Fragile, Technology Dependent (MTFD) Children	DSCC
Supportive Living Program	HFS

See ***https://hfs.illinois.gov/medicalclients/hcbs.html*** for detailed information on each waiver.

Statewide Transition Plan

In February 2023, CMS approved the Department's Statewide Transition Plan (STP) for compliance with the federal requirements for HCBS settings specified in 42 CFR 441.301(c)(4).

In addition to receiving federal STP approval, states were required to conduct heightened scrutiny reviews of HCBS provider settings with institutional qualities, as defined by CMS, to ensure those settings were compliant with all federal HCBS settings requirements, thus overcoming CMS' institutional presumption. To confirm the state's review was thorough, CMS began conducting on-site visits to a sample of heightened scrutiny settings per state. In October 2022, CMS visited five Illinois heightened scrutiny settings. In December 2022, the Department received a report from CMS outlining compliance concerns. The Department developed and submitted a remediation plan to Federal CMS in January 2023.

In partnership with HCBS waiver operating agencies, the Department met with impacted HCBS provider agencies and case management entities regarding the concerns, disseminated corrective action plans (CAPs), and completed all remediation activities by March 2023.

States were also required to present evidence of heightened scrutiny setting compliance for public and CMS review. In November 2022, CMS requested that states without final CMS adjudication of Heightened Scrutiny settings submit CAPs. Like many states, HFS had not received CMS feedback on Illinois' heightened scrutiny compliance evidence and submitted a CAP on 12/07/2022. On 06/17/2023, the Department received a CAP approval letter from CMS. Upon receiving final adjudication of Illinois heightened scrutiny settings from CMS, the Department will collaborate with the HCBS waiver operating agencies to establish any necessary remediation activities.

Information and updates regarding the Department's federal HCBS Settings implementation efforts can be found at: ***https://hfs.illinois.gov/medicalclients/hcbs/transition.html***.

Consistent with the quality pillars of equity and community-based services and supports, the Department worked with the HCBS waiver operating agencies to set forth policies and practices that offer individuals receiving HCBS the same rights and access to their communities as experienced by individuals without HCBS. Beyond final STP approval, the Department has collaborated with HCBS waiver operating agencies to update quality assurance monitoring processes to ensure continued compliance with federal HCBS settings requirements, introduce new Informational Bulletins to support HCBS provider and case manager compliance, and update person-centered Planning documents to capture all documentation requirements laid out in the settings rule.

Waiver Expenditures & Customers Served

Note: *All data was compiled from the Enterprise Data Warehouse (EDW). This year, enrollment and expenditures were calculated differently than in past FY reporting, as complete HCBS waiver encounter data is now available for reporting. Past reports calculated totals using capitation rates. Using MCO encounter data improves accuracy of this data. FY2023 figures are preliminary and are expected to increase due to waiver expenditure data reported up to 18 months after expenditures are incurred. In FY2023, enrollment numbers began to decline as customers were reassessed for eligibility as the COVID-19 PHE came to an end.*

Quality Assurance

The Department is committed to ongoing assessment and identification of opportunities for improvement to ensure delivery of the highest-quality HCBS services. The Department's goal is to maximize the quality of life, functional independence, health, and well-being of Medicaid waiver customers through data analysis and systems improvements which follow rigorous federal quality improvement requirements. The Department's quality improvement process of discovery, remediation and system improvement promotes the health, safety and welfare of customers by monitoring waiver performance measures, analyzing patterns and trends, and establishing systemic enhancements.

The Department has updated the HCBS waiver performance measures to align measures across all Illinois waivers. Consistency among the nine waiver programs will allow the Department to compare compliance among operating agencies and MCOs.

LTC Rebalancing

Illinois is currently in the Planning Phase for the Money Follows the Person (MFP) program. The purpose of MFP is to increase the use of HCBS rather than institutional services for Medicaid eligible customers who meet an institutional level of care.

In August 2022, CMS announced Illinois as one of five states and territories selected to receive an MFP Planning Phase award of nearly $5 million to begin September 1, 2022. The purpose of the Planning Phase is to: (1) assess for gaps in current community-based long-term services, supports, and resources; (2) expand and positively impact recruitment and retention of direct care workers and the full range of needed home-based providers; and (3) design an Operational Protocol to define the MFP Implementation Phase. HFS has been working in collaboration with DHS, DOA, the Illinois Housing Development Authority (IHDA), and the University of Illinois Chicago (UIC), as well as advocates, potential participants, stakeholders, and other interested parties to complete these Planning Phase activities.

In FY2024, Illinois plans to submit the MFP Operational Protocol to CMS for review, approval, and potential award of up to an additional $5 million per year through 2027. Approval of this protocol will allow the Department and collaborating agencies to begin transitioning MFP eligible customers, defined as those residing in an institutional setting for greater than 90-days who are interested in community-based living, and providing the full range of services and supports under the MFP program.

These MFP services and supports include Qualified, Demonstration, and Supplemental Services. Qualified Services are services typically covered by Medicaid, including State Plan and HCBS waiver services, and Demonstration Services are services typically covered by Medicaid but not necessarily available to the population of people being served. Both Qualified and Demonstration Services are eligible for an enhanced Federal Medical Assistance Percentage (FMAP). Supplemental Services are services not typically covered by Medicaid (e.g., moving expenses, short-term rental assistance, home furnishings, food) that can be considered covered for MFP customers at 100%. Despite the large funding amounts, MFP has been shown to be a cost-savings program for the federal and state governments since community-based LTSS are less expensive and more conducive to quality of life than institutional-based LTSS.

Illinois is also vetting numerous direct care worker training curriculums and direct care worker directory locator platforms, is seeking to expand the Illinois Housing Locator usage, and is investigating other opportunities to maximize current HCBS resources. UIC is serving a pivotal role in these endeavors, as well as having a role in the proposed MFP Implementation Phase with training, data tracking and reporting, and quality initiatives.

HOSPITAL SERVICES

HOSPITAL PROVIDER REIMBURSEMENT

Overall spending on hospital claims totaled $5.4 billion in FY2023, a 12% increase over the $4.9 billion spent in FY2022. The growth is due to an increase in both inpatient and outpatient utilization.

252 Cost-reporting hospitals participated in the Illinois Medicaid program in FY2023

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 includes those customers covered under the FFS program and by an MCO. 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.

Inpatient Hospital Services - General Revenue Fund (GRF)

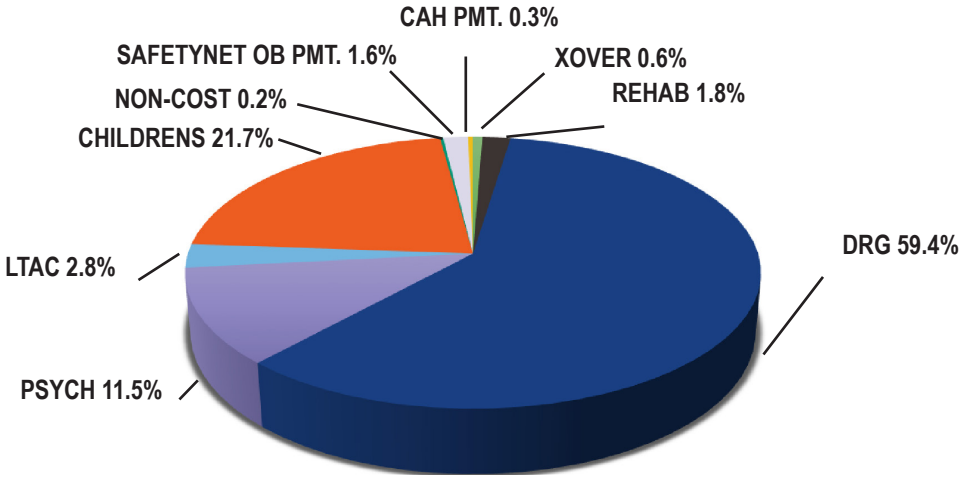
Inpatient hospital claims consist of acuity-based groupings, called All Patient Refined Diagnosis Related Groups (APR-DRG) with several specialized claims-based add-ons, including disproportionate share, safety-net, psychiatric, Medicaid Percentage Adjustment and Medicaid High Volume Adjustment. Some types of claims are excluded from the 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 FY2023 hospital inpatient liability, including payments for both FFS and Encounter claims totaled $3.1 billion, up 12% from the $2.852 billion spent in FY2022. This corresponds with a 7% increase in total inpatient admissions. To advance the goal of improving child and maternal health outcomes, the Department paid $50 million through GRF funded supplemental payments to safety net hospitals that provide inpatient obstetric services with an emphasis on those that provided over 1,000 deliveries annually and $10 million to Critical Access Hospitals with an emphasis on those that have a perinatal designation from the DPH.

As shown in the following graph, 59% of the $3.17 billion in state FY2023 hospital inpatient payments were made pursuant to the APR-DRG based system, a decrease from the 63% in FY2022.

2023 GRF Hospital Inpatient Spending - $3.17 Billion

Inpatient FY2023 % of Total Payments



Ambulatory Care Services

The Enhanced Ambulatory Patient Grouping (EAPG) system works like the inpatient DRG system, assigning like procedure codes to an EAPG group and assigning relative weights to the groups based on national averages of resource consumption to provide the services.

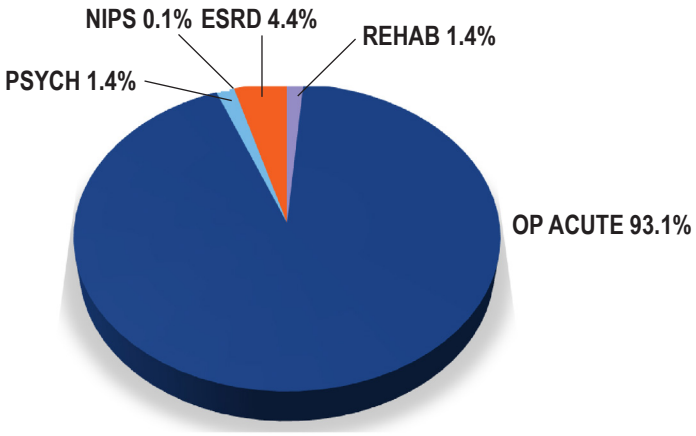
This system allows hospitals to be paid for multiple procedures on one claim and incorporates discounting and consolidation of payments when appropriate.

Total spending on outpatient claims paid via the EAPG system rose 13% to $2.3 billion in 2023 over the $2.0 billion in 2022. That spending increase was accompanied by a 9% increase in the number of outpatient services provided, from 8.3 million services in 2022 to 8.9 million in 2023.

Much like the inpatient spending, most hospital outpatient spending is for directed customer acute claims reimbursed through the EAPG, as well as some renal payments.

2023 GRF Hospital Outpatient Spending - $2.3 Billion

Outpatient FY2023 % of Total Payments



Disproportionate Share Hospitals (DSH)

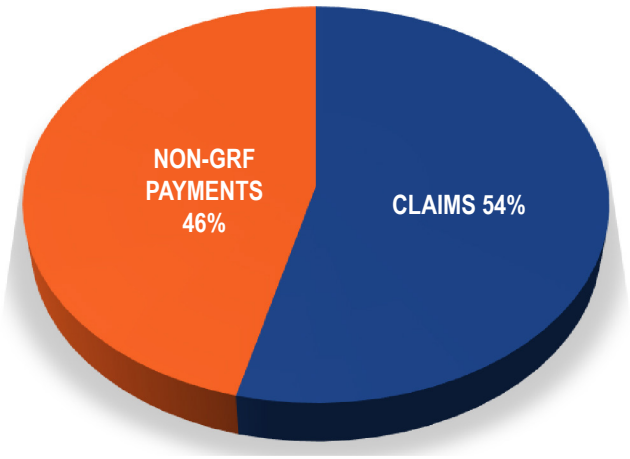
Federal law requires hospitals that serve a disproportionate number of low-income customers with special needs be given an appropriate increase in their inpatient rate or payment amount. Additionally, states are federally mandated to provide the increased payment to any hospital whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate or whose low-income utilization rate exceeds 25%. In FY2023, the Department expended $319.7 million of its federal DSH allotment, which equated to about $588.3 million in total spending, including state matching funds.

The following numbers of hospitals qualified for DSH in rate year 2023: 82 private (non-governmental) hospitals, including 27 which received DSH payments because they were within the federal guidelines set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1993; 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.

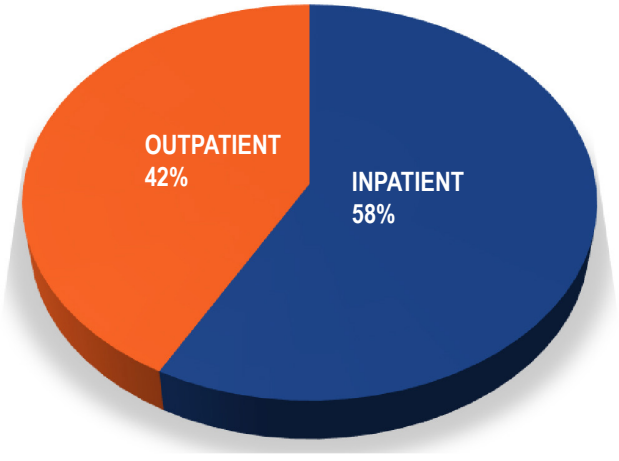
Non-GRF Funded Hospital Payments

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, the Department 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 $4.6 billion in payments were made to the hospitals in FY2023 through supplemental payments and graduate medical education (GME) payments made directly to the hospitals and through MCOs in the form of directed payments and passthrough payments. Of that, $447 million was special Hospital Pandemic Recovery Stabilization Payments as authorized by Public Act 102-1115.

Total FY2023 Hospital NON -GRF Payments vs Claims



FY2023 Hospital Payments Inpatient vs Outpatient



Adjustments to Hospital Assessments

Effective July 1, 2020, the hospital assessment program includes payment methodologies that can fluctuate each quarter of the year, resulting in the state's financial liability being higher or lower than the original amount of the hospital tax assessed to fund those payments. To fund this, the Department may adjust the tax on an annual or semi-annual basis by subtracting the modeled payments from the actual payments during the previous assessment period and multiplying by .3853 to account for the state's estimated liability for the payments.

For the period of January 2023 through July 2023, the amount of actual payments over the modeled amount was $560,268,523. Therefore, the tax adjustment was an increase of $215,871,461. See details below:

Tax Increase Calculations for 07/01/2022

Actual Payments 01/01/2023– 06/30/2023	$2,135,701,501
Less Modeled Payments	$1,575,432,978
Payment in Excess	$560,268,523
	x .3853
Tax Increase	$215,871,462

Aggregate payment amounts for the period of July 1, 2023 through December 31, 2023 totaled $461 million more than modeled. To fund these payments, the tax adjustment implemented January 2024 of $177,755,426 is detailed below.

Tax Increase Calculations for 01/01/2024

Actual Payments 07/01/2022 – 12/31/2022	$2,034,982,183
Less Modeled Payments	$1,573,639,266
Payment in Excess	$461,342,917
	x .3853
Tax Increase	$177,755,426

Utilization Review & Quality Assurance

The Department utilizes a Quality Improvement Organization (QIO) to provide required quality assurance and FFS utilization review activities for services provided in inpatient hospital settings. The contracted QIO vendor, eQHealth/Kepro recently rebranded as Acentra Health. In FY2023, the QIO conducted a total of 47,629 reviews corresponding to 31,560 hospitalizations through either the concurrent or retrospective review process. HFS realized a direct cost savings of $3.01 million for non-certification of medically unnecessary services. A total of 62 "quality of care" concerns were also identified and monitored as part of a quality improvement plan for each relevant provider during this reporting period.

PHARMACY SERVICES

PHARMACY SERVICES

Covered Drugs and Utilization Management
In accordance with federal Medicaid law, coverage of prescription and certain over-the-counter (OTC) drugs is limited to products made by companies that have executed rebate agreements with federal CMS. This encompasses the vast majority of pharmaceutical manufacturers, and substantially all drugs.

The Department, in conjunction with the Drugs and Therapeutics Advisory Board, controls access to certain drugs via a prior authorization (PA) process. Drugs subject to PA are regularly evaluated based upon the safety, efficacy, and costs for covered medications. The Drugs and Therapeutics Advisory Board is comprised of nine clinicians, appointed by the Governor, to provide clinical review and advisory recommendations. This panel meets quarterly for the purpose of conducting drug reviews.

This year the Department began accepting claims from pharmacies, where the pharmacists are the prescriber for both HIV drugs and contraceptives.

Preferred Drug List/Supplemental Rebate Program

The Department continues to develop and maintain a Preferred Drug List (PDL) which can be found 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 UIC 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 Drugs and Therapeutics Advisory Board reviews the Department's PDL proposals in each therapeutic class for clinical soundness. Through the PDL process, HFS negotiates and contracts for supplemental drug rebates directly with drug manufacturers.

Supplemental rebates are collected on all applicable drug claims. These supplemental rebates are above and beyond the rebates provided by the manufacturers under the federal drug rebate program. In FY2023, the Department collected approximately $215,842,990 million in state supplemental rebates from drug manufacturers. In addition to supplemental drug rebates, the Department collected $155,442,914 million in rebates on blood glucose testing equipment and durable medical equipment supplies.

Critical Access Pharmacy Program

The Critical Access Pharmacy Program was set up to benefit pharmacies located in medically underserved areas of the state. The professional dispensing fee for Illinois-based Critical Access Pharmacies is $15.55. This dispensing fee was added to MCOs claims in 2023. Critical Access Pharmacies, for purposes of the professional dispensing fee, are identified as pharmacies:

- Physically located within Illinois counties with less than 50,000 residents;
- Whose owner(s) do not have ownership or controlling interest in ten or more pharmacies;
- That are brick and mortar stores (meaning the pharmacy location is open to the public);
- Where customers present to fill prescriptions; and,
- Where the majority of the pharmacy's business is not mail-order based or through delivery to a residential facility and which is not owned/operated by a hospital or located within a hospital.

Narcotics Management Program

The Department has constructed a multi-pronged approach to identify and manage drug utilization for customers 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. In consultation with the Drugs and Therapeutics Advisory Board, the Department has made a limited number of narcotics available without PA. Managed care oversight occurs through the MCO's required customer restriction program where, at a minimum, the MCO must restrict a customer for a reasonable period to a designated PCP or provider of pharmacy services when:

1. HFS indicates the enrollee was included in the Department's Recipient Restriction Program pursuant to 89 Ill. Admin. Code 120.80; 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).

All PA requests for customers with a clinical profile indicating the customer's utilization should be managed closely result in a comprehensive review of the customer's Medicaid prescription history, as well those prescriptions that are reported through the Illinois Prescription Monitoring Program.

Pharmacy programs participating in the Medicaid program must have a Drug Utilization Review (DUR) Program which includes 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.

New in 2023: the Department initiated an initial fill limit of five days on opioids if the customer had not received a narcotic within the previous 60 days. This allows for closer monitoring of opioid naive customers.

Specialty Drug Use

The Department has implemented utilization controls, including PA 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.

Four Prescription Policy

The FFS program has a Four Prescription Policy Program, which identifies opportunities to improve efficacious drug therapy. The Department prioritizes a patient-centered approach to medication management identifying issues such as utilization control edits implemented to address duplicate therapy, drug interactions, inappropriate use, and quantity and duration of therapy. Providers review a customer's entire medication regimen and, where possible and clinically appropriate, reduce duplication, unnecessary medications, and polypharmacy. Additional information on the Four Prescription Policy Program is available at: ***https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/FourPrescriptionPolicy.aspx***.

Hemophilia Care Management Program

Through the Department's Hemophilia Care Management Program, quality and utilization control initiatives for customers with hemophilia who are receiving blood factor continue to prove effective. The Department requires PA for blood factor products to ensure appropriate utilization. Further information can be found at: ***https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/Hemo.aspx***.

In addition, the FFS program requires providers to have a signed Standard of Care Agreement (SOCA) on file in order to be reimbursed for the dispensing of blood factor.

BEHAVIORAL HEALTH SERVICES

BEHAVIORAL HEALTH SERVICES

The Department is focusing on improving both services and outcomes for adults and children who have mental health and substance use disorders, collectively referred to as behavioral health needs. This focus is evident in the Department's quality pillars that establish the goals of improving integration of physical and behavioral health services, improving transitions from inpatient to community-based services, improving access to care for customers with alcohol and/or other substance use disorders, and reducing avoidable psychiatric hospitalizations and/or emergency room visits through enhanced community-based services and Mobile Crisis Response (MCR). While the Department worked closely with the MCOs to realize these goals, HFS also developed, implemented and/or enhanced several programs and initiatives for children and adults with behavioral health needs to continue to improve the overall behavioral health service system.

Advancing Our Quality Pillars

- Adult Behavioral Health
- Child Behavioral Health

Standardized, Statewide Integrated Assessment and Treatment Plan

The Department recognized that the behavioral health system needed standardization, continuity, and consistency in identifying a customer's behavioral health treatment needs as well as their strengths. To meet this need, the Department developed and implemented the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) in February of 2019.

In January 2021, the Department launched a web-based IM+CANS Provider Portal to allow all providers to upload data from completed IM+CANS into a central database. The data collected allows the Department to tailor services to meet customer's specific needs. Since the portal's launch through June 30, 2023, a total of 414,475 distinct IM+CANS have been entered into the portal.

Upon implementation of the IM+CANS and the IM+CANS Provider Portal, providers identified several areas in need of enhancements. In response to feedback, the Department established the IM+CANS Workgroup to provide a structured meeting format where providers could bring concerns, develop recommendations, and assist HFS in implementing adopted recommendations. The IM+CANS Workgroup met monthly throughout FY2023 and presented actionable recommendations to the Department that will be implemented in the following months. The partnership between the Department and providers has been extremely beneficial in enhancing the implementation and utilization of the IM+CANS.

Children's Behavioral Health Programs and Initiatives

To enhance the overall children's behavioral health system, the Department launched a new set of services and supports known as **Pathways to Success**. Authorized under a new 1915(i) HCBS State Plan Amendment, Pathways to Success includes enhanced care coordination through high-fidelity wraparound and intensive care coordination as well as additional services, including intensive home-based, therapeutic mentoring, respite, family peer support and therapeutic and individual support services.

Eligibility for Pathways to Success is based on the Department's Behavioral Health Decision Support Model that includes data pulled from the IM+CANS Provider Portal for children under the age of 21 with complex behavioral health needs, illustrating how the IM+CANS standardized assessment information is utilized to match children with appropriate services.

To ensure that care coordination is provided with fidelity to the wraparound model, the Department established Care Coordination and Support Organizations (CCSOs) responsible for offering high-fidelity wraparound, intensive care coordination, individual support services, and therapeutic support services. The Department began enrolling children into Pathways to Success in December 2022, starting with one CCSO serving 22 children. By June 2023, the Department had referred 1,469 children to CCSOs for Pathways to Success enhanced care coordination.

CCSOs also play an integral role in other children's behavioral health services including the Family Support Program (FSP) and Specialized Family Support Program (SFSP) and in providing Mobile Crisis Response (MCR) for all customers in their designated service area (DSA).

FSP is a state-funded program open to any youth who meets eligibility criteria, regardless of Medicaid-eligibility. Eligible youth can receive community-based mental health services and can access in-state residential treatment if they require more intensive services. In FY2023, 488 youth were served through FSP.

SFSP was implemented pursuant to the Custody Relinquishment Prevention Act (20 ILCS 540). It is a collaborative effort between HFS, DCFS, DHS, the Department of Juvenile Justice (DJJ), 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. By leveraging 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. In FY2023, 21 youth were referred to SFSP.

Mobile Crisis Response (MCR) services were first introduced within the Illinois Medicaid program following passage of the Children's Mental Health Act of 2003 (Public Act 93-0495), which required the Department to develop protocols for screening and assessing children and youth prior to any publicly funded admission to an inpatient hospital. In response to this requirement, the Department, in collaboration with DCFS and DHS, developed the SASS program. Since July 2004, the SASS program has operated as a single, statewide MCR system serving children and youth experiencing a mental health crisis. SASS operates 24 hours a day, 7 days a week for children and youth in the FFS program. 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 requires MCR services, and refers the call to the most appropriate community resource, which may include the dispatch of a SASS crisis responder.

As the state's Medicaid infrastructure began to evolve through the introduction of MCOs, the state's approach to crisis response also evolved. Many of the children and youth traditionally served by the SASS program are now being served by MCR programs administered and funded by the MCOs. MCR continues to feature centralized intake via the CARES line and 24/7 access to immediate face-to-face crisis intervention services. The Department actively works with the MCOs to ensure coordination and continuity of care across the multi-payer crisis response system.

By requiring CCSOs to provide MCR, the Department has connected care coordination with MCR, which has been shown to assist in stabilizing youth with complex behavioral health needs in their communities and reduce their admission to psychiatric hospitals. In FY2023, the CARES line received 108,457 calls, of which 103,777 were due to a crisis, and there were 19,560 unique children/youth who received MCR.

Integrated Care for Kids (InCK) Model Grant

Since FY2019, the Department has partnered with two provider organizations, Ann & Robert H. Lurie Children's Hospital of Chicago and Egyptian Health Department, to implement the Integrated Care for Kids (InCK) Model grant. The InCK Model is a child-centric service system and state payment model that seeks to 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.

- In FY2023, Lurie Children's Hospital continued to build their provider network and infrastructure. After successful implementation efforts, an estimated 1,200 needs assessments were completed. Lurie has contracted with Medicaid health plans and has implemented an Alternative Payment Model (APM) that increased funds to sustain the Lurie InCK model.
- In FY2023, Egyptian Health Department completed significant grant implementation efforts as the needs assessments exponentially increased from 597 youth to 1,200 youth within one calendar year. Egyptian Health Department partnered with five health facilities to help expand the InCk care coordination network. In addition to increasing program enrollment, an APM has been created among four health plans that are anticipated to be in effect in early 2024.

The University of Illinois' Office of Medicaid innovation (OMI) continues to assist with data flow between the providers and the Department as it pertains to claims and attribution files. OMI has also continued to work with the providers to develop APMs to support ongoing InCK services.

Children's Behavioral Health Transformation Initiative

The Department has been an active participant in the Children's Behavioral Health Transformation Initiative, established by Governor Pritzker in March 2022 with the goal of improving the delivery of behavioral health services to children and adolescents with significant and complex behavioral challenges, as well as to streamline and simplify the ways in which families can access resources, services, and support for the youth in their care. The Department participates in weekly Interagency Crisis Staffing Team calls to help families access behavioral health services, including residential treatment, and also assisted in the development of the Blueprint for Transformation that outlined key recommended strategies to centralize and streamline children's behavioral health services, adjust current capacity to better meet the needs of families who need behavioral health services, and intervene early with behavioral health services to help prevent escalation of youth's needs and ultimate utilization of residential and inpatient psychiatric hospitalization. The Department is a key partner in this Transformation Initiative and will continue to support the needed enhancements to the children's behavioral health system.

Certified Community Behavioral Health Clinics (CCBHC)

To further support the integration of mental health, SUD, and physical health services, the Department established a program for the implementation of Certified Community Behavioral Health Clinics (CCBHC). A CCBHC is a federally defined provider type in Medicaid, designed to provide a comprehensive range of behavioral health and physical health services to all individuals seeking services, regardless of the individual's ability to pay. In return, CCBHCs receive a provider-specific prospective reimbursement rate based on their existing costs and any anticipated costs for expanding services to meet the needs of all individuals. CCBHCs are responsible for directly providing (or contracting with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care. CCBHCs integrate additional services to ensure an approach to healthcare that emphasizes recovery, wellness, trauma-informed care and physical-behavioral health integration.

To support the implementation of CCBHCs in Illinois, the Department applied for a federal Demonstration grant that would help to offset costs for the Department to plan for implementation of CCBHCs. The Department applied for the Demonstration in December 2022 and was notified that the grant would not be awarded to Illinois in March of 2023. However, the Department was invited to apply for the federal Demonstration grant to support implementation of CCBHCs in calendar year 2024. The Department began preparing for the federal demonstration opportunity by developing a process for interested providers to apply to participate in the Demonstration application, developing a certification process for those providers, establishing a mechanism for developing prospective rates and gathering input from stakeholders on all aspects of CCBHC implementation. Planning activities will continue into FY2024.

1115 Waiver Illinois Behavioral Health Transformation

The Department also continued to provide access to substance use recovery services through the Illinois Behavioral Health Transformation 1115 Waiver. The Department, in partnership with the DHS-Division of Substance Use Prevention and Recovery (DHS-SUPR), implemented four SUD specific pilots:

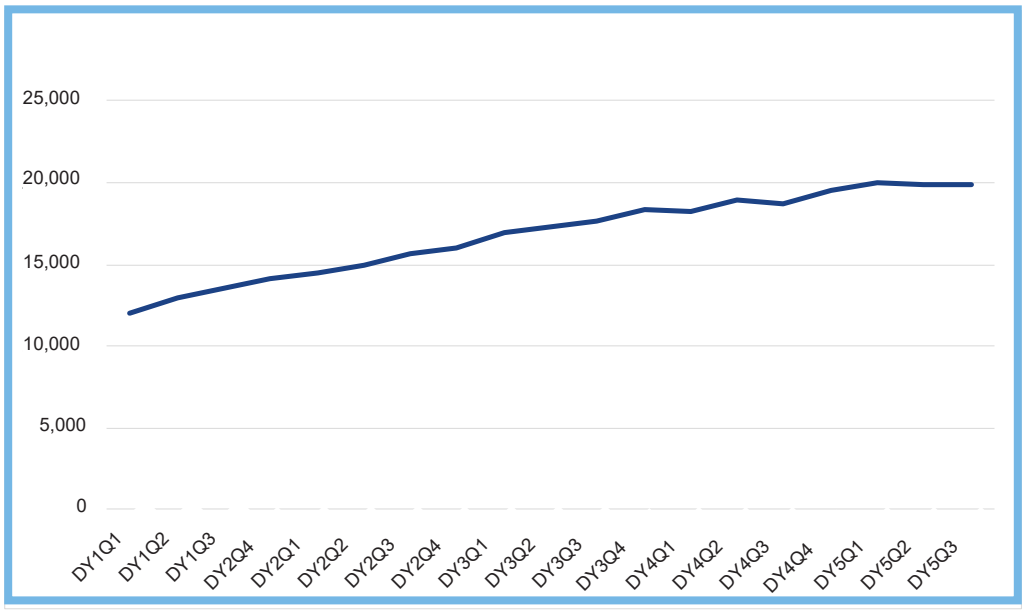
- Residential/Inpatient SUD Treatment in an Institution for Mental Disease (IMD)
- Case Management to individuals with an SUD that qualify for diversion into treatment from the criminal justice system
- Peer Recovery Support Services
- Clinically Managed Residential Withdrawal Management for individuals with SUD.

These pilots include Opioid Use Disorder (OUD)/SUD services delivered by providers licensed by DHS-SUPR. Providers of Clinically Managed Residential Withdrawal Management must have the ability to coordinate or provide Medication Assisted Treatment (MAT) for those customers who need this regimen of care. In the first five years of the 1115 waiver (July 1, 2018 through June 30, 2023) there were an estimated:

- 16,522 customers who received treatment through the SUD residential IMD Pilot
- 5,207 customers who were enrolled in SUD case management services
- 229 customers enrolled in Peer Recovery Support Pilot
- 99 customers enrolled in the Clinical Withdrawal Management Pilot

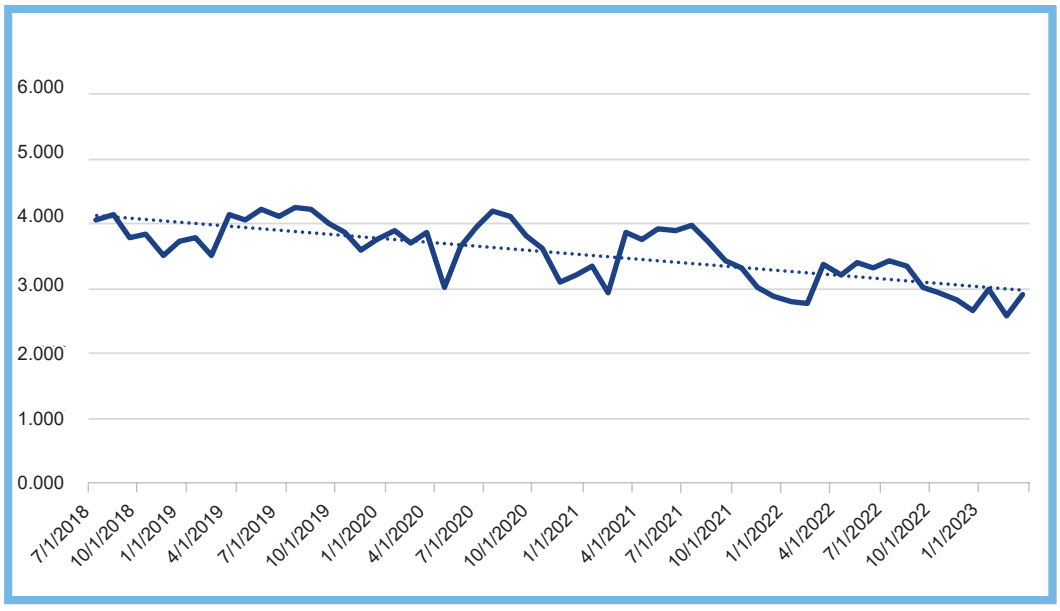
Illinois tracks key metrics designed to help assess progress toward the achievement of the milestones. The Department reports on these metrics on a quarterly basis. During the demonstration period, the number of beneficiaries receiving MAT increased 53% since the beginning of the waiver, going from 11,988 beneficiaries per quarter to 19,855 per quarter.

Medication Assisted Treatment



The total overall rate for Emergency Department (ED) visits for SUD per 1000 customers decreased from 4.1 per 1000 to 2.92 per 1000, a 28% decrease since demonstration year one. Customers aged 40–64 years have been the highest utilizers of the ED for SUD issues. However, during the demonstration period, the rate per 1000 for this age group saw a 38% decrease from 11.1 to 7.1 per 1000 customers.

Emergency Department Utilization for SUD per 1,000

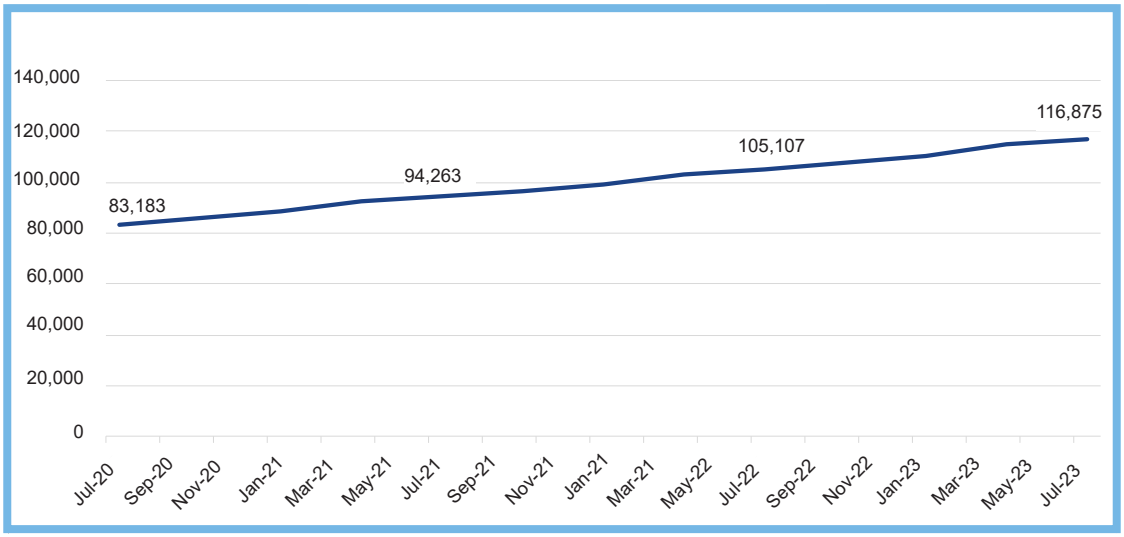


Capacity Planning Grant - Illinois SUPPORT Initiative

Additional support for substance use recovery services was provided through a Section 1003 Demonstration Project to Increase Substance Use Provider Capacity (SUPPORT Act Demonstration) with a project period from September 30, 2021 to September 29, 2024.

The SUPPORT Act Demonstration is intended to build SUD treatment and recovery service provider capacity. Illinois was one of fifteen states awarded a planning grant ($4.5 million) in September 2019, and one of five states to receive the 36-month Demonstration in September 2021. During FY2023, a primary objective of the SUPPORT Act Demonstration was to increase the number of providers in Illinois that deliver SUD services (provider availability). The number of providers enrolled in Medicaid and qualified to deliver SUD services has increased 40% since July 2020. In FY2023, the number of providers enrolled in Medicaid and qualified to deliver SUD treatment services increased by 11.2% over FY2022.

Total SUD Provider Ability



The number of providers who are enrolled in Medicaid and qualified to deliver MAT (Buprenorphine and or Methadone) for an SUD during the measurement period has almost doubled since the first quarter, July 2020. In FY2023 the availability of SUD providers qualified to deliver MAT has increased 10.8%.

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. The births of over 80,000 babies are covered by the Department every year. The Department serves as an advocate in promoting wellness through a continuum of comprehensive health care programs that address issues such as perinatal healthcare for birthing persons, social emotional development, immunizations, lead screening, and family case management.

Advancing Our Quality Pillars

- Equity
- Maternal and Child Health

See the perinatal report issued by the Department on the status of prenatal and perinatal health services at: ***https://hfs.illinois.gov/medicalproviders/maternalandchildhealth/report.html***

In 2020, the Department identified maternal and child health as one of its quality pillars. In addition, Illinois became the first state to receive federal approval to extend full benefit Medicaid coverage through 12 months postpartum with continuous eligibility and federal matching dollars. HFS also received federal approval to extend postpartum coverage from 60 days to 12 months for immigrants in the five-year waiting period as well as to undocumented immigrants – another first in nation.

The Department continues to assess maternal and child health outcomes and continues to make improving maternal health and birth outcomes a priority. HFS is working to implement new coverage of services and provider types, including: doulas, lactation consultants, home visiting programs, community health workers, and certified professional midwives. In addition, the Department is implementing a new Medicaid partial benefit Family Planning Program. Improving the health status of mothers and children can be achieved through education, prevention, and partnerships with other agencies and stakeholders.

The MCOs also play a vital role in meeting the healthcare needs as this partnership with the Department extends the reach in the delivery of services provided. MCOs 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. Additionally, timely prenatal care is the selected MCO Performance Improvement Project (PIP), requiring the MCOs to work to identify and close a disparity gap in this area. More information on the Maternal and Child Health programs offered by HFS can be found at: ***https://hfs.illinois.gov/medicalclients/maternalandchildhealth.html***

Local Health Department (LDH) Partnerships

The Department has re-instated Medicaid administrative claiming for maternal child health programs, including Family Case Management (FCM), High Risk Infant Follow-Up, and the Better Birth Outcomes programs funded by DHS grants. This program existed for many years for FCM; however, it has been updated to include other programs that also reflect the Department's quality pillars, specifically maternal child health. The Department advances this quality pillar by enabling LHDs to claim additional reimbursement for maternal child health program costs.

Federal Medicaid rules allow LHDs to recoup a portion of their actual costs for maternal child health services provided to Medicaid customers if their costs are greater than their DHS grants. This is an opportunity for LHDs to expand their funding for services they already provide, but participation is not mandatory. In FY2023, LHDs received approximately $800,000 in paid administrative claims.

Telehealth Audit

The expansion of telehealth services during the COVID-19 PHE allowed for continuity in healthcare for customers who could not receive in-person care, while bringing healthcare to underrepresented communities. Telehealth utilization increased from 0.05% of professional claims prior to the PHE to a high mark of 6% by FY2021. Current trends show 3.8% of claims are provided as telehealth services. Audio only services accounted for 30% of all telehealth services in FY2023.

The Department added a new telehealth quality assurance measure in 2023. To check the quality of telehealth claim submissions, an audit sample of telehealth service claims were assessed to ensure that the telehealth was an appropriate mode of care to meet the customer's needs and were billed in compliance with Department policies.

Dental Services

The FFS dental program is administered by DentaQuest of Illinois, LLC (DentaQuest). The Department, through DentaQuest, offers many dental services to children and adults. DentaQuest is responsible for dental claims adjudication and payment, PA of services, ongoing reporting to the Department, and quality assurance monitoring. In addition, DentaQuest provides services aimed at ensuring customer access to care for medically necessary dental services such as provider recruitment and training, customer education and referral coordination, an interactive website, and call center services.

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.

FY2023 Dental Payments

	Number of Individuals	Dental Services	Payments
Individuals under 21	64,463	483,112	$12.5 million
Individuals 21 and over	88,920	668,602	$26.9 million
Total	**153,383**	**1,151,714**	**$39.4 million**

For more information, visit the Department's Dental Program webpage at: ***https://hfs.illinois.gov/medicalproviders/dental.html***

Bright Smiles from Birth Program

The Department, 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 FQHCs on how to perform oral health screenings, assessments, and fluoride and varnish applications.

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; studies confirm that fluoride varnish applications are effective at reducing early childhood cavities in young children. See ***https://illinoisaap.org/oral-health/*** for more information.

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). In April 2023, federal approval was received to expand the program and provide funding to LEAs for medical services provided to any Medicaid-eligible child with services documented on a plan of care, not just those with an IEP. This reimbursement allows students to receive medical and behavioral healthcare in their community and increases the availability of access to care. For more information visit: ***https://hfs.illinois.gov/medicalprograms/sbhs.html***

Advancing Our Quality Pillars

- Child Behavioral Health
- Maternal and Child Health
- Community-Based Services and Supports

Approximately 195,000 children received direct medical and behavioral health services through the school-based program during FY2023. LEAs were reimbursed over $104.9 million for their costs to provide these services, as well as about $82.2 million for care coordination costs and outreach.

PROGRAM INTEGRITY

PROGRAM INTEGRITY

The Office of Inspector General (OIG) for the Department reports to the Governor of Illinois and has a statutory mandate "to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct" in Illinois' Medicaid program. (305 ILCS 5/12-13.1) To fulfill this mission, OIG has various powers and authorities to ensure program integrity, including:

- Investigating misconduct by employees, vendors, contractors, and medical providers;
- Prepayment and post-payment auditing of medical providers;
- Monitoring and measuring quality assurance and quality control; and
- Initiating administrative actions against contractors, vendors, and medical providers for terminations, recoupment of overpayments, payment suspensions, and application denials.

OIG is composed of various bureaus including the Bureau of Medicaid Integrity, the Bureau of Investigations, and the Bureau of Fraud Science and Technology. The work of these bureaus is highlighted below.

Bureau of Medicaid Integrity (BMI)

Audits: 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. OIG uses various factors in determining the selection of providers for audit, including, but not limited to, data analysis; fraud and abuse trends; identified vulnerabilities of the Medicaid program; external complaints of potential fraud or improper billing; and a provider's category of risk.

OIG's audits may either be desk audits, field audits, self-audits, or self-disclosures. BMI's program integrity auditors conduct desk and field audits. At times, BMI auditors require providers to conduct self-audits to identify potential overpayments. A self-disclosure results from a provider identifying and raising a potential overpayment with BMI's audit section as the result of the provider's own investigations and review of its billing practices.

BMI's audit section also has oversight responsibility for audits conducted by OIG's federally-mandated, external auditors—the Recovery Audit Contractor (RAC) and the Universal Program Integrity Contractor (UPIC). Federal law requires states to establish programs to contract with a RAC to audit payments to Medicaid providers. OIG uses RAC vendors to supplement its efforts for all provider and audit types. The federal CMS Center for Program 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.

Peer Reviews of Providers for Quality of Care: The Peer Review Unit (PRU) conducts quality of care reviews and monitors service utilization rendered to Medicaid customers by reviewing records submitted by a current provider or new applicant. Quality of care concerns are categorized as risk of harm, medically unnecessary care, or grossly inferior quality of care. Risk of harm is identified when there is a risk to the customer that outweighs the potential benefit of the service. Medically unnecessary care is identified when the care provided to the customer is not needed or is in excess

of the customer's needs. Grossly inferior quality of care is identified when flagrantly poor care is provided to a customer. The PRU nursing staff and physicians conduct reviews of physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. PRU cases can originate from hotline complaints, internal referrals, or external agencies such as the Illinois Department of Financial & Professional Regulation (IDFPR), State Police, DPH, or MCOs.

After a thorough review of a selection of provider records, PRU staff may recommend case closure with no concerns; sending an education letter to the provider identifying minor concerns; or a referral to an OIG physician consultant for further review of potentially serious concerns. The physician consultant, in turn, may recommend an education letter and corrective action for minor concerns or, for more serious concerns, a Medical Quality Review Committee (MQRC) meeting to discuss the provider's care and services. The MQRC is composed of OIG staff and two to three OIG medical consultants from the same specialty as the subject provider. As a result of its review, the MQRC may close the case; send a letter to the provider identifying the concerns, corrective action required, and specifying a time for a re-review; refer the matter internally or externally for further action; or recommend that OIG take administrative action such as termination, entry of a corporate integrity agreement, suspension, or denial of reinstatement or enrollment.

If a provider was terminated, suspended, or withdrew from the Program previously and submits a new enrollment application, a reinstatement case will be created and sent to the PRU to conduct a quality-of-care review. Similarly, if a Program applicant has an action or discipline noted on their license, an enhanced enrollment case will be created and sent to PRU to conduct a quality-of-care review.

Long Term Care Asset Discovery Investigations Unit: The Long Term Care Asset Discovery Investigations Unit (LTC-ADI) 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 when they apply for state assistance. The goal of the unit is to ensure that individuals applying for LTC services do not have excess resources nor recently made unallowable transfers of resources that would allow them to pay for their own nursing home care.

By preventing improper conduct related to eligibility, LTC-ADI ensures program funds go to qualified applicants who have no other means to pay for their own care.

The DHS Family Community Resource Centers (FCRCs) refer applications to OIG when they meet specific criteria. LTC-ADI analysts complete reviews of financial records and applicant information up to five years before the date of their application for benefits. OIG issues findings to the FCRCs to allow DHS to send out notices advising the applicants of their eligibility for the program.

Quality Control Measurements: Quality Control reviewers within the BMI work with federal CMS to identify incorrect eligibility determinations that have resulted in improper service payments funded under the Title XIX or Title XXI programs. Errors identified result in a recoupment of funds by CMS. Quality Control staff ensure the individual cases are corrected and complete and monitor a Corrective Action Plan (CAP) for all case errors and discrepancies. The CAP requires the cooperation and assistance of various Department areas such as policy, systems, and training. The purpose of the CAP is to reduce and eliminate future errors and avoid the recoupment of state funds.

Recipient Restriction: The Recipient Restriction Program (RRP) was established to ensure effective and safe utilization of medical and pharmacy benefits by recipients and avoid overuse in the Medical Assistance Program. By assigning at-risk recipients to one PCP, primary care clinic and/or primary care pharmacy, the recipient will receive all medical care and coordination of their medical services by that primary provider. Emergency and in-patient hospital services and services for complex diagnoses are not restricted.

The primary source of identifying recipient overuse is a predictive analytic model run in OIG's Dynamic Network Analysis (DNA) system. OIG analysts review cases flagged by DNA for medical necessity. Other sources of recipient identification include incoming referrals from medical providers, law enforcement officials, or members of the general public. During the review process the recipient's medical usage for the preceding 24 months is reviewed. When fraud, waste, or abuse of medical services is identified, the analysis is forwarded to an OIG physician or pharmacy consultant for recommendations. When Medicaid benefits are determined to be overused or medically unnecessary, the consultant will place the at-risk recipients on a Recipient Restriction 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.

Bureau of Investigations (BOI)

New Provider Verification: The BOI's New Provider Verification Unit (NPV) reviews certain providers' enrollment applications for concerns such as past convictions or sanctions. NPV gathers additional information and makes a recommendation to OIG leadership as to whether to grant or deny the enrollment application.

NPV continues to monitor new providers that are designated as high and moderate risk for fraud based on their provider type. Provider claims are analyzed 180 days after enrollment and again after one year. As a part of that process, the NPV analyst contacts the provider to offer guidance and answer any questions they may have. If no concerns are identified after a year of monitoring, then the provider becomes a fully enrolled Medicaid provider. If problems are identified, the matter is presented to OIG's Provider Review Committee, which may decide to extend the provider's conditional enrollment or to disenroll the provider.

Complaint Intake: BOI's Complaint Intake Unit (CIU) serves as the central fraud intake unit for OIG. The CIU processes fraud and abuse referrals received from MCOs, local DHS offices, members of the public, and other stakeholders, alleging potential fraud by Medicaid providers and customers. Referrals are processed via phone hotline, online intake referral sites, as well as through direct communication with state and federal agencies and law enforcement entities.

CIU conducts thorough research on fraud allegations by accessing databases from a variety of sources including, but not limited to, DHS, Secretary of State, State Police, DPH vital records, Department of Employment Security and the Division of Child Support Services. Based on CIU's initial investigation and review, OIG then determines what further action to take on the allegation, if any.

Provider Investigations: Historically, BOI only investigated allegations of suspected fraud, waste and abuse by recipients of federal benefits. In recent years, BOI expanded its focus to include investigations of Medicaid providers. In the course of its investigations, BOI works with the Illinois Medicaid Fraud Control Unit, state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies. As the result of BOI's investigation against a provider, OIG may refer the matter for criminal prosecution or seek administrative sanctions through its legal office.

Recipient Investigations: BOI also investigates whether identified recipients have manipulated the system by submitting false information 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 or federal agencies.

Bureau of Fraud Science and Technology (BFST)

Dynamic Network Analysis: The OIG BFST oversees the development and maintenance of the DNA system. OIG uses DNA's robust and comprehensive data analytics to help ensure Medicaid program integrity and compliance. Using DNA, BFST has developed various statistical models and routines to support detection of potential Medicaid fraud and abuse. These models and routines are based on OIG managers, auditors, and investigators' needs; user feedback; and system audit logs. Some examples include the following:

Provider Profile and Recipient Profile: BFST's Provider Profile Report and Recipient Profile Report are the most complex and comprehensive reports generated by the DNA system. The Provider Profile Report combines information from multiple data sources and applied statistical approaches for a targeted Medicaid provider. The Recipient Profile Report provides an overview of a recipient's history, demographics, enrollment data, and medical service summary to assist OIG in determining the need for further investigation. The Provider and Recipient Profile Reports are widely used in complaint analysis, responses to Federal requests, and ad hoc requests from various agencies.

Early Warning System: BFST's Early Warning System combines various critical indicators to identify exceptions to the norm and predict potential abuse and fraudulent activities by at-risk providers. The module uses the providers' billing and payment activities from the most recent five-year period. The early warning system is a proactive model that ranks providers by their provider type in multi-dimensional views. This allows the user to scan providers and identify potential fraudulent targets. To define the at-risk severity of each provider, the model concentrates on providers with unusually high payments, volume of recipients, services compared to peers, common clients compared to other providers, number of prescriptions involving controlled or narcotic drugs, and questionable billing patterns.

Opioid Usage Dashboard: Opioid misuse and overdoses are a grave national health concern. By using the opioid calculation toolkit from the Office of the Inspector General of the U.S. Department of Health & Human Services, BFST developed an opioid monitoring dashboard. This dashboard allows users to visualize usage trends of opioid-related drugs by MME level for the past five years. The selected view displays payment, services, patients, and the number of involved pharmacies. The report provides a summary of opioid usage by prescriber, patient, and drug type. Different measures identify those at risk of opioid misuse or overdose.

Statistical Validation on Recoupment Calculation: After an OIG auditor completes a review of records and identifies errors, BFST assists to establish the provider's overpayment through interpretation and extrapolation. Auditors upload their findings to the Statistical Verification module in the DNA system and an automated workflow is triggered. The automated workflow performs a systematic statistical validation and estimates the recoupment amount in consideration of different sampling scenarios.

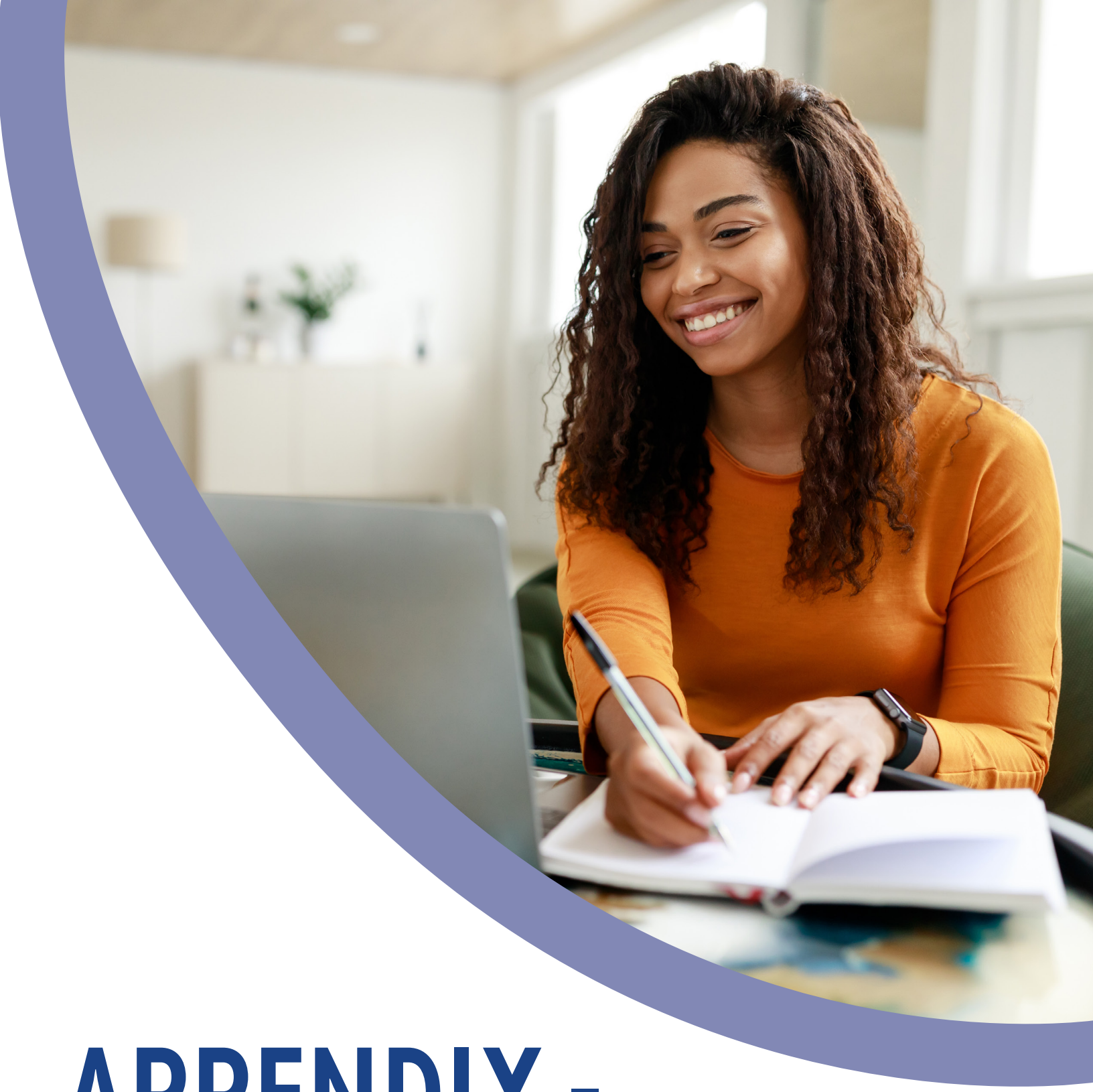
Transportation and Psychotherapy Predictive Modeling: BFST uses predictive modeling to detect and predict provider fraud through statistical analysis and data mining. BFST's transportation and psychotherapy predictive models allow increased efficiency in identification of potentially problematic providers. A risk score ranging between zero and one is assigned to each provider to indicate the potential risk of a provider being engaged in Medicaid fraud. Consequently, rankings allow a comprehensive evaluation of providers to identify potential targets of fraud.

Post-Mortem Analysis: BFST's Post-Mortem Analysis identifies claims of deceased recipients submitted by any provider type. Data sources used to validate recipient death information come from DPH, the HFS EDW, CMS, and the Social Security Administration's death master file.

Other OIG Bureaus

In addition to the Bureaus of Medicaid Integrity, Investigations, and Fraud Science and Technology, OIG operates other areas relevant to the Department's medical assistance programs. OIG's Bureau of Internal Affairs investigates misconduct by the Department and DOA employees, contractors, and vendors. The Office of Counsel to the Inspector General prosecutes administrative sanctions against Medicaid providers, including terminations, overpayment recoupments, payment suspensions, and eligibility denials. Finally, OIG's Fiscal Management Unit collects overpayments that were made to providers.

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 FY2023

The following services are required to be provided by the Department in the Medicaid, CHIP, and certain All Kids programs:

- Certified pediatric and family nurse practitioner services
- Emergency service for non-citizens
- Emergency 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
- Medical/surgical services by dentist
- Medication Assisted Treatment (MAT)
- Nurse midwife services
- Nursing facility services (age 21 and over)
- Outpatient hospital services
- Physician medical and surgical services
- Routine patient costs of items and services for customers enrolled in qualifying clinical trials
- Rural health clinic services
- Tobacco cessation counseling for pregnant women
- Transportation to covered medical services

Optional Services Provided in FY2023

The following services are covered by the Department in the Medicaid, CHIP, and certain All Kids programs but are not required to be covered under federal law:

- Acupuncture services, limited to procedures related to lower back pain and breech baby treatment
- Case management services
- Certified Registered Nurse Anesthetist
- Chiropractic services
- Clinic services
- Clinical Nurse Specialist
- Dental services, including dentures
- Diagnostic, screening and preventive services, including diabetes programs and Adaptive Behavior Support (ABS) 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 intelectual disabilities, including state-operated facilities
- Licensed Clinical Professional Counselors services
- Licensed Clinical Social Worker services
- Licensed Marriage and Family Therapists services
- Licensed Psychologist services
- Nursing facility services for individuals under 21 years of age
- Occupational therapy services
- Optometry services
- Pharmacist services, limited to specific birth control and HIV services
- Physical therapy services
- Podiatric services Prescribed drugs
- Prosthetic devices
- Rehabilitative services (Medicaid Rehab Option)
- School- Based Health
- Speech, hearing and language disorder services
- State plan home and community-based services through a 1915(i)
- TB related services
- Transplant services

TABLE II

THE DEPARTMENT MEDICAL ASSISTANCE PROGRAM Expenditures Against Appropriations - FY2021 - 2023 *Dollars in Thousands*						
	FY2021 Expenditures	**Percent**	**FY2022 Expenditures**	**Percent**	**FY2023 Expenditures**	**Percent**
Total[1,2]	**$19,596,759.7**	**100.0%**	**$22,150,629.4**	**100.0%**	**$25,382,678.6**	**100.0%**
Hospitals	**1,076,175.0**	**5.5%**	**1,020,346.1**	**4.6%**	**1,131,598.0**	**4.5%**
Long Term Care[3]	**472,896.7**	**2.4%**	**409,509.7**	**1.8%**	**562,791.7**	**2.2%**
Practitioners	**233,186.3**	**1.2%**	**228,287.3**	**1.0%**	**282,924.0**	**1.1%**
Physicians	196,555.9	1.0%	186,733.3	0.8%	233,843.4	0.9%
Dentists	31,122.7	0.2%	36,706.8	0.2%	43,511.4	0.2%
Optometrists	4,091.9	0.0%	3,548.8	0.0%	3,942.2	0.0%
Podiatrists	1,405.1	0.0%	1,286.6	0.0%	1,614.3	0.0%
Chiropractors	10.4	0.0%	11.8	0.0%	12.7	0.0%
Drug	**800,495.0**	**4.1%**	**911,038.7**	**4.1%**	**1,096,917.5**	**4.3%**
Other Medical	**1,492,975.2**	**7.6%**	**2,397,729.0**	**10.8%**	**2,298,798.0**	**9.1%**
Laboratories	45,965.1	0.2%	79,301.6	0.4%	79,779.0	0.3%
Transportation	151,464.5	0.8%	562,832.9	2.5%	682,643.4	2.7%
SMIB/HIB Expansion[4]	625,730.5	3.2%	753,836.6	3.4%	779,280.9	3.1%
Home Health Care/ DSCC	199,094.4	1.0%	192,356.8	0.9%	203,670.7	0.8%
Appliances	25,567.0	0.1%	28,475.1	0.1%	34,037.9	0.1%
Other Related[5]	230,884.0	1.2%	569,596.1	2.6%	300,853.9	1.2%
Community Health Centers	40,585.3	0.2%	62,391.4	0.3%	55,249.8	0.2%
Medically Complex Development (MCDD)[6]	123,440.2	0.6%	116,052.5	0.5%	118,317.3	0.5%
Hospice Care	50,514.2	0.3%	32,886.0	0.1%	44,956.1	0.2%
Managed Care	**15,521,031.5**	**79.2%**	**17,183,718.6**	**77.6%**	**20,009,658.4**	**78.8%**
Children's Health Rebate	**0.0**	**0.0$**	**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 Includes funds from the Provider Assessment Program, IMDs and SLFs.

3 Includes amounts paid via offsets to federal financial participation draws.

4 "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 FY2023.

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 customers;
- 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.

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 Medicaid customers; 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.