HFS
Illinois Department of
Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, HFS Director

FY 2022

ANNUAL REPORT

Medical Assistance Program

April 1, 2023

HealthChoice
Illinois

A LETTER FROM THE DIRECTOR

Theresa Eagleson, Director

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

On behalf of the Department of Healthcare and Family Services (HFS), I am pleased to present the Fiscal Year 2022 Annual Report of the Department's medical assistance programs – often also known generally as Medicaid. Every day, we advance the commitment of 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 as we empower our customers to maximize their health and well-being.

In addition to ongoing efforts to help our customers and providers respond to COVID-19, we have been leading a range of transformation projects and initiatives. Among these accomplishments, the Department completed a major upgrade of the Hospital and Managed Care Organization (MCO) assessments. We've also become the first in the nation to implement three major advances: an equity driven nursing home model, post-partum coverage for twelve months regardless of immigration status and medical coverage for undocumented adults age 42 and older.

In our existing programs, we began to offer added diabetes coverage and more telehealth options. Greater reproductive health access is being made available with a new family planning program, new pharmacist contraception services and increased provider rates. Additional Healthcare Transformation Collaboratives were also selected, further promoting equity in communities across the state.

This report provides details on these and many other specific initiatives, as well as participant numbers and provider reimbursements for Fiscal Year 2022 (and, in some instances, for the two previous years for purpose of comparisons and statutory requirements).

We are committed to engaging with all of our stakeholders to continually improve the way we help those we serve. I hope you find this report informative and useful as we work together to ensure the Department brings the right care at the right time and place to all those we serve.

Sincerely,

Theresa Eagleson

Theresa Eagleson, 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

The Department provides medical coverage to approximately one quarter of the State's population. Enrollment as of June 30 for the last three completed fiscal years (FY) (Illinois' FY is from July 1 to June 30) is as follows:

Comprehensive Benefits	FY 2020	FY 2021	FY 2022
Children	1,406,402	1,465,904	1,499,514
Adults with Disabilities	253,204	252,650	246,842
ACA Newly Eligible Adults	641,711	774,007	868,108
Other Adults	523,468	640,548	741,991
Seniors	230,270	260,929	288,600
Total Comprehensive	3,055,055	3,394,038	3,645,055
Partial Benefit Enrollees	46,984	46,467	47,275
Total Enrollees	**3,102,039**	**3,440,505**	**3,692,330**

HEALTH CARE PROGRAMS

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

All Kids Assist

Eligibility - Children up to age 19 with family income at or below 147% of the Federal Poverty Limit (FPL) ($3,399 per month for family of four (4)).
Presumptive Eligibility - Yes **Benefit** - Comprehensive **Cost Sharing** - No

All Kids Share

Eligibility - Children up to age 19 with family income above 147% and at or below 157% FPL (between $3,400 and $3,631 per month for a family of four (4)).
Presumptive Eligibility - Yes **Benefit** - Comprehensive **Cost Sharing** - No

All Kids Premium Level 1

Eligibility - Children up to age 19 with family income above 157% and at or below 209% FPL (between $3,632 and $4,833 per month for a family of four (4)).
Presumptive Eligibility - Yes **Benefit** - Comprehensive **Cost Sharing** - No

All Kids Premium Level 2

Eligibility - Children up to age 19 with family income above 209% and at or below 318% FPL (between $4,834 and $7,354 per month for a family of four (4)).
Presumptive Eligibility - No **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 $4,926 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 ($3,191 per month for a family of four (4)) for adults.
Presumptive Eligibility - No **Benefit** - Comprehensive **Cost Sharing** - Yes

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 $1,563 for an individual or $2,106 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 ($1,133 for a single person and $1,526 for a couple) and no more than $2,000 of non-exempt resources for one person and $3,000 for the first two people and further increased by $50 for each additional dependent.
Presumptive Eligibility - No **Benefit** - Comprehensive **Cost Sharing** - No

1619A and 1619B

Eligibility - Individuals who are employed. 1619(a) individuals have employment earnings low enough to receive some portion of a Supplemental Security Income (SSI) check. 1619(b) individuals have higher earnings and receive no SSI income benefits.
Presumptive Eligibility - No **Benefit** - Comprehensive **Cost Sharing** - No

Health Benefits for Workers with Disabilities (HBWD)

Eligibility - Employed persons, ages 16 – 64, with disabilities and earnings up to 350% FPL ($3,964 per month for an individual, $5,340 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. 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 - Persons 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 group.
Presumptive Eligibility - No **Benefit** - Partial **Cost Sharing** - No

Medicare Saving Program (MSP)

Eligibility - There are three (3) programs for individuals eligible for Medicare Part A; Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (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 $8,400 for a single person and $12,600 for a couple.
Presumptive Eligibility - No **Benefit** - Coverage of Medicare cost sharing expenses
Cost Sharing - Not Applicable

Health Benefits for Immigrant Adults

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

Health Benefits for Immigrant Seniors

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. Eligibility criteria is otherwise similar to MAGI.
Presumptive Eligibility - YES **Benefit** - Family Planning and Family Planning related services.
Cost Sharing - No

The following are the health care services administered by HFS for customers who are ineligible for Medicaid and for which providers submit claims directly.

State Hemophilia Program

Eligibility - Eligibility - Any Illinois resident with health insurance and a bleeding or clotting disorder who is not eligible under another group.
Presumptive Eligibility - No **Benefit** - Partial **Cost Sharing** - Yes

State Chronic Renal Disease Program

Eligibility - Illinois residents with health insurance who meet citizenship requirements and are not eligible for coverage under Medicaid or Medicare who require lifesaving care and treatment for chronic renal disease but are unable to cover the out-of- pocket costs.
Presumptive Eligibility - No **Benefit** - Partial **Cost Sharing** - Yes

State Sexual Assault Survivors Emergency Treatment Program

Eligibility - Survivors of sexual assault who are not enrolled in another group.
Presumptive Eligibility - No **Benefit** - Partial **Cost Sharing** - No

Client Hotline Numbers

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

All Kids	1-866-255-5437
Client (Illinois Health Benefits & All Kids Hotline)	1-800-226-0768
Drug Prior Approval/Refill-Too-Soon	1-800-252-8942
4 Our Kids (Medical Programs Health Benefits & All Kids Hotline)	1-866-468-7543
Client Eligibility – AVRS for Providers Only	1-800-842-1461
Prior Approvals	1-800-642-7588
TTY (for hearing impaired) Handled by Next Talk	1-877-204-1012
Client Eligibility – AVRS for Clients (medical coverage questions)	1-855-828-4995
Kids Now (Federal Toll Free Number connecting directly to the Medicaid or CHIP Staff in the state from which the call is made. In Illinois, it connects to the Illinois Health Benefits and the All Kids Hotline.)	1-877-543-7669

PROGRAM COSTS

During FY 2022, HFS spent approximately $28.96 billion (all funds), of which $22.15 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 FY 2022 spending by appropriation line).

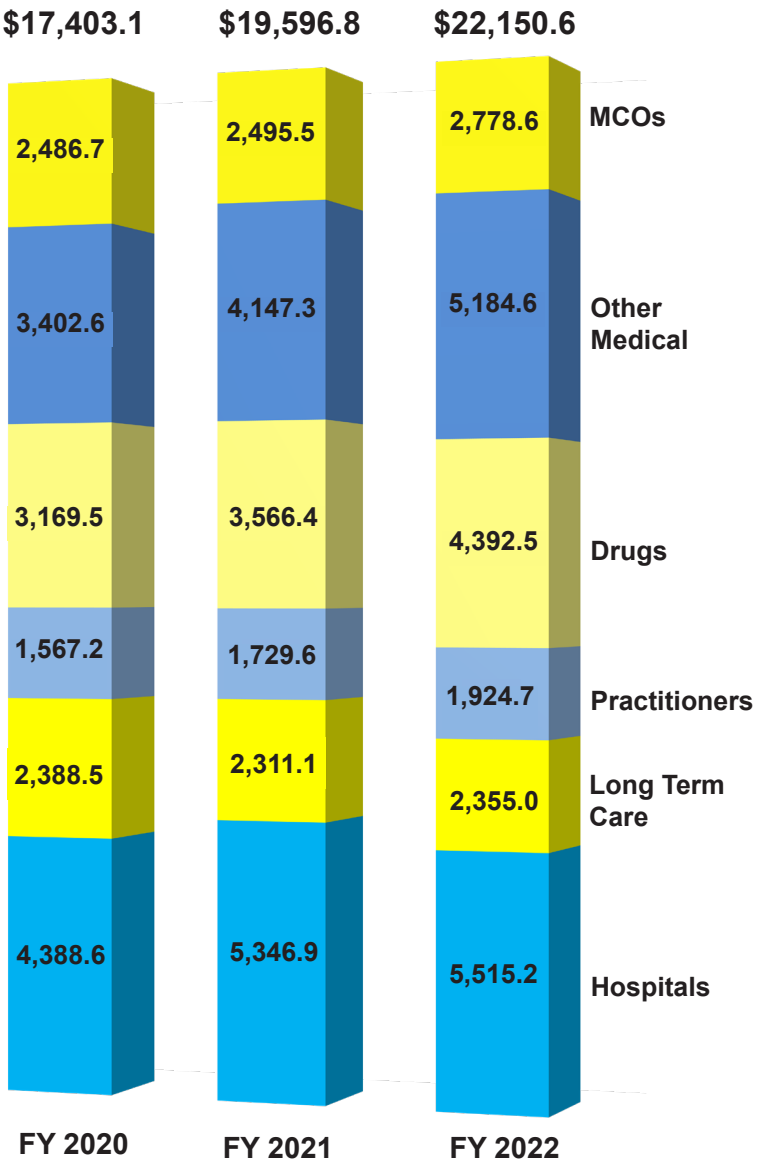
Medical Programs Spending

FY 2020 - 2022 Dollars in Millions

2020 - Managed Long Term Services & Support (MLTSS) program expanded state-wide during FY 2020 along with new MCO programs, YouthCare & Special Needs Kids. The Managed Care Assessment was initiated which provided a new revenue source for the Medical Assistance Program, reduced the Program's reliance on general funds by $503 million and allowed $598.9 million in program investment in addition to maintaining actuarially sound MCO rates reflecting the imposition of the assessment. The Medically Complex Development Disorder (MCDD program transitioned to HFS from DHS.

2021 - Enrollment has increased over 11% during the Public Health Emergency. The Department instituted a supplemental rate increase for Ground Emergency Medical Transportation.

2022 - Enrollment has increased over 7% during the Public Health Emergency. Other Medical increases are due to Medicare A & B Premiums calendar year 2022 federal rate increase, over $350 million increase for hospital pandemic surge staffing, and the shift of emergency medical transportation costs from MCO capitated rates back to fee for service rates. Drugs increase due to Medicare Part D Clawback calendar year 2022 federal rate increase along with enrollment growth.



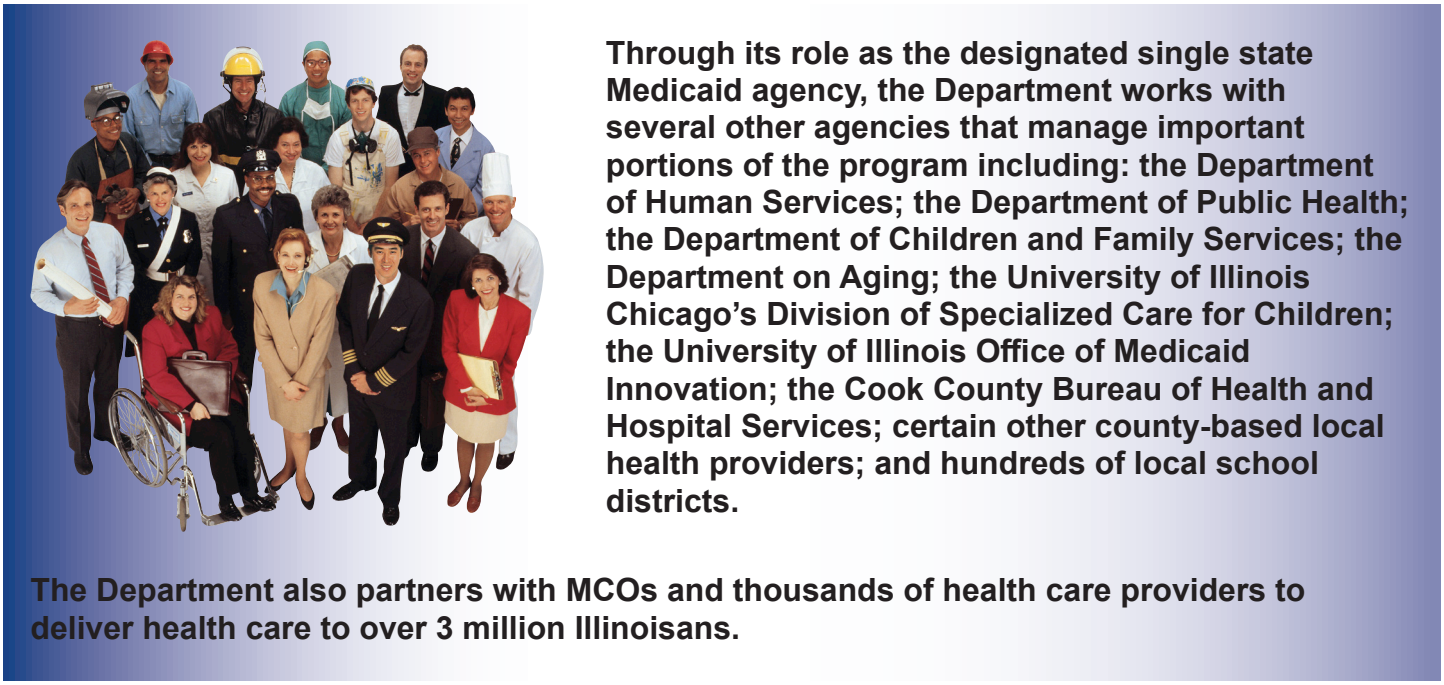
Notes: Not included in total spending are expenditures from the (Cook) County Provider Trust, University of Illinois Hospital Services, Non-entitlements, Hospital Provider Fund (relating to the assessment), Trauma Center, Special Education Medicaid Matching, Money Follows the Person Budget Transfer, 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.
Graph Prepared By: Division of Finance

Data Source: Division of Finance, Comptroller Spending Report FY'20-'22.



Through its role as the designated single state Medicaid agency, the Department works with several other agencies that manage important portions of the program including: the Department of Human Services; the Department of Public Health; the Department of Children and Family Services; the Department on Aging; the University of Illinois Chicago's Division of Specialized Care for Children; the University of Illinois Office of Medicaid Innovation; the Cook County Bureau of Health and Hospital Services; certain other county-based local health providers; and hundreds of local school districts.

The Department also partners with MCOs and thousands of health care providers to deliver health care to over 3 million Illinoisans.

ENABLING LEGISLATION

The Department administers its Medical Assistance Programs under the Illinois Public Aid Code (305 ILCS 5/), the Children's Health Insurance Program Act (215 ILCS 106/), the Covering ALL KIDS Health Insurance Act (215 ILCS 170/), and Titles XIX and XXI of the federal Social Security Act.

TRANSFORMATION

TRANSFORMING MEDICAL ASSISTANCE

HFS continued improving services for our customers and responding to emerging needs and opportunities in communities throughout Illinois. Among transformational leadership we have advanced:

- Significant revamp of Hospital Assessment to meet federal requirements and implementation of MCO assessment to reduce GRF reliance
- First in the nation to provide post-partum coverage for 12 months regardless of immigration status
- First in the nation to offer medical coverage to undocumented adults aged 42 and older
- New coverage for diabetes prevention and management programs
- A rapid pivot to a telehealth-enabled service delivery mechanism to better serve our customers and provide financial stability to providers
- Ensured no customers lost Medicaid coverage during the Public Health Emergency
- Standing up the Pathways to Success program for children with behavioral and mental health needs

Healthcare equity and addressing the social determinants of health are at the center of our mission. Several initiatives are specifically focused on this critical vision.

- Second round of payments to Healthcare Transformation Collaboratives, which will provide more than $70 million to reduce racial inequities and address social determinants of health
- First in the nation to reform the nursing home industry with a new equity-driven payment model. These reforms will bring increased funding tied to staffing levels and key quality measures, as well as a new pay scale for certified nursing assistants
- MCO performance management focused on results broken out by race, ethnicity, and geography
- Program of All-Inclusive Care for the Elderly (PACE) program to help seniors throughout Illinois receive more community-based care is being prepared to launch in mostly black and brown ZIP codes

Technology Transformation

Developing a state-of-the art technology platform continued in FY 2022. This platform replaces a decades old system that inhibited efficient and effective reporting, analytics, and timely decision making. The new systems are designed to enhance program integrity and increase efficiency while reducing costs. Major system milestones include:

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

Advancing Our Quality Pillars

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

While advancing the effort to complete the final and last phase of the HFS technology milestones, HFS is working to make sure that the new system(s) will fully support the program changes that help the Department meet our Quality Pillars, plus reduce the programmatic time needed to achieve new goals in the future.

Quality Assurance

State Quality Assessment and Performance Improvement Strategy for Managed Care

The Department developed its Comprehensive Medical Programs Quality Strategy in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.340 et seq.

Advancing Our Five Quality Pillars

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

The Quality Strategy is designed to foster the delivery of the highest quality, most cost-effective services possible by establishing a framework for ongoing assessment and the identification of potential opportunities for healthcare coordination and improvement. The Department is committed to improving outcomes by addressing social and structural determinants of health and by empowering customers to maximize their health and well-being. HFS is committed to making equity the foundation of everything it does.

The Quality Strategy establishes a framework and a vision for the improvement of ongoing assessments and the identification of potential opportunities for health care coordination and ensuring the delivery of the highest quality and most cost-effective services possible. The HFS Quality Strategy prioritizes equity across all program goals as the ultimate aim for improvement efforts by analyzing data to strategically pinpoint improvement needs. To support the Departments mission of health Equity and to drive progress 5 pillars for improvement were developed as it restructured the P4P and Pay for Reporting measures. The Department monitors these measures to work with the healthplans on improving outcomes within these measures. Health plans are required to report on the measures assigned to each pillar by race, ethnicity, gender, and preset zip codes. The Department meets with the plans quarterly to review their specific data. Health plans are asked to review their outcomes, discuss analysis of the data, any root cause analyze completed and targeted interventions put in place related to the outcomes. In addition, the Department holds a quarterly quality meeting with plans to go over general data outcomes and to allow guest speakers to discuss services available and best practices. The five pillars and the measures within each pillar included:

Pay for Performance	Pay for Reporting
Adult Behavioral Health	
• Follow-up After Hospitalization for Mental Illness (7 and 30 day) • Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 and 30 day)	• Follow-up after High-Intensity Care for Substance Use Disorder (7 and 30 day) • Pharmacotherapy for Opioid Use Disorder

Child Behavioral Health

- Follow-up after Hospitalization for Mental Illness-ages 6-17 (7 and 30 day)
- Follow-up after Emergency Department Visit for Mental Illness-ages 6-17 (7 and 30 day)
- 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

Maternal and Child Health

- Prenatal and Postpartum Care (timeliness of care)
- Childhood Immunization Status-Combo 3
- 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

Equity

- Breast Cancer Screening
- Cervical Cancer Screening
- Controlling High Blood Pressure
- Adults' Access to Preventative/Ambulatory Health Services
- Human Immunodeficiency Virus Viral Load Suppression
- Gap in HIV Medical Visits
- Prescription of HIV Antiretroviral Therapy

Community Based Services and Supports

- Long-Term Services and Supports-Comprehensive Care Plan and Update
- Successful Transition After Long-Term Care Stay

Vision for Improvement - Program Goals

The Department is Committed to Improving Health Outcomes and Equity

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 for infants and children

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

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

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

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 individual

External Quality Review Organization

Federal regulation (***42 CFR Part 438 Subpart E***) requires that specific review activities be performed on MCOs by an EQRO:

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

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

- Quality Assurance Plan Compliance Review (e.g. readiness reviews for new plans prior to implementation and monitoring the quality of services and supports provided to HCBS participants);
- Overall Evaluation of the Quality Strategy;
- Technical Assistance on Quality Assurance Monitoring of MCOs and the Department (at the direction of the Department);
- A separate annual Consumer Assessment of Health Care Providers and Systems (CAHPS) survey for both the Medicaid Program and the Children's Health Insurance Program (CHIP) which includes questions on children with chronic conditions.

CARE COORDINATION

CARE COORDINATION

HealthChoice Illinois
Illinois Department of Healthcare and Family Services

Overview

During FY 2022, the statewide HealthChoice Illinois (HCI) MCO Program offered most Medicaid customers enhanced health care coordination and quality services at sustainable costs. The Department, in collaboration with the MCOs and key stakeholders, including healthcare associations, hospitals, and other providers, are realizing improved efficiencies around billing, payment, administration, and other systems, continuing to create improvements in customers lives by focusing on social and structural determinants of health, increasing education and outreach to assist in empowering customers to maximize their health and well-being, and working toward maintaining the highest standards of program integrity with equity as the foundation of quality improvement.

Advancing Our Quality Pillars

- Equity

As of January 1, 2023, almost 80% of Illinois Medicaid customers were enrolled in comprehensive, risk-based MCOs. For more enrollment information by county, MCO and managed care program by month, visit the HFS ***Facts & Figures page*** and the ***Care Coordination page*** on its website. In addition to enrollment information, these links include information on enrollment by population type, percentage of customers who actively selected an MCO vs. being auto assigned to a plan, and customer language preference. The Department updates the data on these links monthly. Additional information on HCI, including a copy of the HCI model contract and amendments between HFS and the health plans, can be found on the ***HFS Care Coordination website***. Information and links specific to helping customers better understand the MCO program can be found ***here***.

Managed Care Programs

The Department operates three distinct care coordination programs within the broader Illinois Medicaid MCO Program: HCI, YouthCare, and the Medicare Medicaid Alignment Initiative (MMAI).

HealthChoice Illinois (HCI)
In FY 2022, HFS held contracts with a total of five (four statewide, plus one Cook County only) qualified, experienced, and financially sound MCO plans to serve the HCI population, including:

- Families and children;
- Adults eligible for Medicaid under the Affordable Care Act
- Seniors and adults with disabilities who are not eligible for Medicare
- Dual Medicare-Medicaid eligible adults receiving certain Long Term Services and Supports, referred to as the MLTSS population
- Special needs children, which includes Former Youth in Care and Youth in Care

The MCO map provides more information about the MCOs that are operating in the HCI program, ***click here***. HCI covers a comprehensive set of benefits for all enrolled customers except the MLTSS population. MLTSS customers receive some long term services and supports, along with some mental health and transportation services, from their HCI health plan. All other services for MLTSS customers are covered by Medicare and the Medicaid fee for service (FFS) Plan.

HealthChoice Illinois - YouthCare
The statewide, specialized HCI health plan, operated by Meridian Health, provides services to Department of Children and Family Services (DCFS) Youth in Care as well as DCFS Former Youth in Care. YouthCare works to improve access to care through active coordination and through a more robust provider network. With YouthCare, DCFS youth receive additional benefits, such as trauma-informed care coordination for behavioral health needs. YouthCare provides specialized programming for adoptive families, including an adoption-competent network of therapists to support the different phases of adoption and child development. The Department continues to work closely with the DCFS and YouthCare and various stakeholders to support program initiatives and workgroups to enhance the quality of care for DCFS youth.

Youth in Care
Youth in Care are youth for whom the Illinois DCFS has legal responsibility, living with foster parents, in group homes, or in residential settings.

Former Youth in Care
Former Youth in Care are youth who have been adopted, are living with kinship providers, have returned to biological parents, and/or have left the DCFS system. All of these youth were in the care of DCFS previously.

Medicare/Medicaid Alignment Initiative (MMAI)
The Medicare/Medicaid Alignment Initiative is an on-going three-way partnership between HFS, the federal Centers for Medicare and Medicaid Services (CMS), and health plans. MMAI reformed the way care is delivered to customers who are eligible for both Medicare and Medicaid services also known as (dually eligible) by providing coordinated care and became a statewide program on July 1, 2021. In FY 2022, a total of five (5) MCOs contracted to provide services under MMAI. The MCO map provides more information about the MCOs that are operating in the MMAI program by county, ***click here***. MCOs providing services under MMAI are responsible for covering all Medicare and Medicaid services, including Long Term Services and Supports. Customers can opt out of MMAI at any time, as well as re-enroll at any time; however, customers who receive services in a nursing facility or under one of the Home and Community Based Services (HCBS) Waivers and request to opt out of MMAI are required to participate in the HCI program under MLTSS. More information can be found on the MMAI section of the HFS website.

Covered Benefits

MCOs must offer the same comprehensive set of services that are available to the FFS plan, such as: physician and specialist care, emergency care, laboratory and x-rays, mental health, pharmacy, dental, vision, substance use services, case management, transportation, and long term services and supports (LTSS). For dual eligible customers enrolled in the MMAI program, customers receive the full range of covered services under the Medicare and Medicaid programs; if either Medicare or Medicaid provides more expansive services than the other program for a particular condition, type of illness, or diagnosis, the MCO must provide the most expansive set of services.

Under HCI, MLTSS enrollees receive Medicare-covered services such as hospitalization, doctor visits, therapies, prescriptions, laboratories, x-rays, and medical supplies are covered through Medicare FFS, Medicare Part D, or Medicare Advantage. Some Medicaid covered services not covered by Medicare are covered under the customers health plan (i.e. long term care, HCBS waiver services, some behavioral health services, non-emergency transportation, and care coordination). All other Medicaid covered services for the MLTSS enrollees are covered through the FFS plan.

All health plans offer extra benefits to enrolled customers, above and beyond what is available under the FFS plan. A chart comparing the extra benefits and services that each health plan offers can be found on the Illinois Client Enrollment Services ***website***.

Ongoing Health Plan Investments

During FY 2022, MCOs continued to invest in critical services and initiatives to help Medicaid customers and providers, such as increasing reimbursement rates for behavioral health providers; ongoing expansion of telehealth capabilities and infrastructure; contracting with vendors and community-based organizations owned by minorities, women, and people with disabilities to increase community engagement in African American and Latin communities; providing technology assistance; extending housing benefits; and continuing to provide food and funding to school-based health centers. All investment activities included a focus on Equity and the Department's Quality Strategies, including the five pillars.

Health plans continued to actively promote COVID-19 vaccinations and boosters and offered ongoing education efforts among members through text messaging, community outreach events, email and phone campaigns, social media, educational videos and print materials. Health plan staff assisted members with making appointments and arranging transportation as well as partnering with provider and community groups to promote and host vaccination and booster events.

Additional information on the Departments' response to the COVID-19 public health emergency can be found ***here***.

Supports for Providers

In FY 2022, the Department continued to recognize the importance of supporting providers in successfully navigating the MCO Programs and encouraging communication between providers and the MCOs. The Department, in partnership with the health plans, continued to provide various supports for providers that are targeted at streamlining administrative requirements across health plans where feasible and providing outlets for providers to report and work through issues they may be having with the MCOs.

Comprehensive Billing Manual for Providers
The Comprehensive Billing Manual, developed in collaboration with the health plans, the Illinois Association of Medicaid Health Plans (IAMHP), and the Department, continued to assist most Medicaid enrolled provider types with Managed Care Program billing questions during FY 2022. The manual compiles in a single source, all MCO plan claims policies and procedures for ease of reference, helps improve provider relations and reduces denials of claims. The billing manual is frequently updated to reflect changes to billing policies and procedures as they are implemented. HFS also issues a Provider Notice with a summary of changes to providers whenever updates to the IAMHP billing manual are published. The comprehensive billing manual can be found on the IAMHP ***website***.

Provider Resolution (Complaint) Portal
Providers that have disputes they are unable to resolve directly with an MCO must submit the complaint to HFS via the secure, web-based ***MCO Provider Resolution Complaint Portal***. Provider complaints submitted via the portal are processed under the provider dispute resolution process and applicable timeframes as required by Public Act 101-0209 (SB1321). The portal encourages communication between the MCO and Provider and is a tool to ensure fair resolution of disputes in an electronic and secure format.

The provider dispute resolution process requires providers to work with the MCO via their internal dispute/appeal process before submitting a complaint to HFS. This means providers must first follow and exhaust all processes provided by MCOs to resolve a dispute, before submitting a complaint through the portal. Once a provider has entered a complaint into the Portal, the MCOs have thirty (30) calendar days to review and issue a written proposal to resolve the disputed complaint ticket. Sanctions are issued to MCOs for untimely portal resolution responses. In 2021, no sanctions were issued to an MCO for an untimely proposal response in the portal. In 2022, 3 sanctions were issued to the MCOs for untimely proposal responses. Copies of sanction letters issued to the MCOs are posted on the Department's Care Coordination Page at the following link:
Sanctions | HFS (illinois.gov)

Admission, Discharge and Transfer (ADT) System
In FY 2022, the Department worked with all of the MCOs to train and connect them to the ADT system. Under this phase, the MCOs began receiving real-time notifications and data on their Medicaid customers including notifications for when a customer visits a hospital or emergency department and discharged from the hospital and nursing facilities. The data sharing helps to connect the MCOs with their customers to provide outreach and follow up care after discharge. Future phases are in process and will enable sharing of other types of data that support the goals of HFS' Comprehensive Medical Programs Quality Strategy, with a focus on the five pillars.

MCO-Provider Association Meetings
HFS continues 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 Administration, IAMHP, the MCOs, and various Medicaid provider groups participating in the MCO Programs. Discussion in these meeting are an opportunity for providers and MCOs to work together to identify and address claiming and billing issues impacting provider payments, to track issues until they are resolved and to provide a platform to work towards improving care coordination and quality in the MCO Programs with a focus on the five pillars. In FY 2022, HFS conducted joint meetings monthly and discussions continued to shift from billing/claims to joint accountability and planning for 2023.

Advance Communication Engine (ACE)
The State's Advance Communication Engine (ACE) has begun capturing 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 the Medicaid billing providers, including hospitals, and improve care coordination services for all MCO customers. Work continues with HFS and the MCOs to create an ACE dashboard with drill down features to analyze the data by MCO, Provider name, type, Safety-Net Hospitals and Behavioral Health facilities. In addition, work continues to capture data in the ACE to identify and report on the top ten reject/denial reasons and top ten reject/denial providers at a future date.

Managed Care Program Consumer Report Cards

As part of its MCO Program Customer Education and Enrollment assistance process, HFS utilizes and publishes a consumer quality comparison tool, called the HCI Consumer Report Card. This tool reflects the performance of each of the HCI health plans by comparing the health plans across key performance areas which align with Department goals and pillar-focused population streams. The six performance areas include: (1) doctors' communication, (2) access to care, (3) women's health, (4) living with illness, (5) behavioral health, and (6) keeping kids healthy. Each plan is assigned up to five stars to indicate how it performs relative to other plans on each measure. The information used to create the Report Card is collected from the health plans and their customers and is reviewed for accuracy by the External Quality Review Organization (EQRO) annually. Samples of the HCI Consumer Report Card are found ***here***.

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 the Department's customers with health care services. The rates are developed based on encounter claims from the MCOs that are validated by our actuaries. Adjustments are made for health care management, trend, and health plan administration. All capitation rates must be actuarially sound in accordance with 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 that the Department determines to be actuarially significant.

Pay for Performance (P4P) and Reinvestment: In addition to capitation rates, the HCI contracts include P4P measures to incentivize spending on care that produces positive quality of life outcomes and to align with HFS' five pillars of improvement. P4P measures are ensured by withholding a percentage amount (Withhold) from the MCOs capitation rate. The MCOs can earn back the Withhold by meeting or exceeding the goals set by the P4P measures.

MMAI Capitation Rates: Both the Federal Centers for Medicare and Medicaid Services CMS and the Department contribute to the global MMAI capitation payments. MMAI MCOs receive three monthly payments for each enrollee: (1) from CMS reflecting coverage of Medicare Parts A/B services, (2) from CMS reflecting coverage of Medicare Part D services, and (3) from the Department reflecting coverage of Medicaid services. The Medicare Parts A/B rate component and the Medicare Part D payment are risk adjusted using the prevailing CMS risk adjustment models. The Medicaid rate component is adjusted based on an customers age, geographic service area, and care setting (nursing facility, waiver, or community), and include a Long Term Services and Supports (LTSS) blended rate based on the nursing facility and waiver enrollment mix in each MCO at the beginning of the calendar year. The nursing facility portion of the blended LTSS rate is risk adjusted.

Directed and Pass-through Payments: Pursuant to CMS-approved directed payment programs and pass-through payments (42 CFR 438.6), the Department may disburse funds to MCOs to issue direct payments to Providers. The Department provides the MCOs with specific instructions each time such funds are disbursed and identify the amount the MCO is to issue to each eligible provider, and the timeframe for making the payments.

Under the MMAI contracts, both Medicare and Medicaid also Withhold a percentage of their respective components of the capitation rate. MMAI plans can earn back their Withholds if the health plan meets or exceeds performance on a combination of core quality Withhold measures across all demonstrations nationally, as well as Illinois-specific quality withhold measures.

Advancing Our Quality Pillars

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

During the reporting period, the Department built on its modified P4P framework so that health plans continue to reinvest in strategies that were directed with a lens toward the five pillars, including Equity. Strategies also considered the greatest impact for organizations and providers that were not already receiving other support, and on customer focused efforts that provided increased care coordination and health services, increased community engagement, expanded access to food pantries, and health rewards programs, across the state, including the disproportionately impacted areas (DIAs). In FY 2022, approximately $74 million of the P4P quality payments were reinvested, 0.5% of the total 2% Withhold. The additional 1.5% of the Withhold was applied to P4P measures with an estimated payback amount of $224 million for measurement year (calendar year) 2021.

Medical Loss Ratio (MLR): MLR means that MCOs must utilize a defined percentage of its capitation rates for health care services, quality improvement, and administrative costs. Under HCI, in 2022, the MLR was 88% (a minimum of 88% must be spent on health care services and quality improvements, and a maximum of 12% may be spent on administrative costs).

Managed Care Program Quality Strategies

The strategies implemented by the Department and MCOs in the Managed Care Programs during FY 2022 aligned with the Department's emphasis on health equity and its Quality Strategy. This work included requiring the MCOs to demonstrate how the health plan will contribute to the access and outcomes of the population that they serve, focus on improving outcomes consistent with the Department's program goals not only for Equity but to also improve on the four pillars - Adult Behavioral Health, Child Behavioral Health, Maternal and Child Health and Community-Based Services and Supports, encouraging opportunities for learning and collaboration with other Agencies and community partners, and identifying resources for quality improvement activities.

For example:

- The Department conducted MCO Quarterly Business Reviews (QBRs) that included a review of each MCOs health Equity efforts and work related to the Quality Strategy, with an emphasis on the pillars. During the QBR sessions the MCOs defined and described their strategies that have been implemented and detail how this work is moving health outcomes and care coordination efforts under each of the 5 pillars. The discussion also includes the MCOs defining and describing their analytics and data to support the strategies and related outcomes.
- Each MCO began submitting an annual Health Equity and Social and Structural Determinants of Health Workplan to the Department. The work plans provide each MCOs commitment to working on the pillars, their plans of action for the coming year, and goals that they hope to achieve, metrics that will be the focus of equity plans of action, such as asthma, diabetes, behavioral health, maternal and infant health, and more. Each MCO plan identifies the data

that has been and will be analyzed and what efforts will be or have been implemented to work toward the goals. The plans also identify, evaluate, and describe efforts to reduce, to the extent practicable, health disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status.

- Each MCO began the process of hiring an Equity Director whose primary role and responsibilities include: overseeing the MCOs strategic design, implementation, and evaluation of health Equity efforts in the context of the MCOs population health initiatives; informing decision-making around best payer practices related to disparity reductions, including the provision of health Equity and social determinant of health resources and research to leadership and programmatic areas; collaborating with the MCOs MIS Director to ensure the MCO collects and meaningfully uses race, ethnicity, and language data to identify disparities; ensuring that efforts addressed at improving health Equity, reducing disparities, and improving cultural competence are designed collaboratively with other contracted MCO entities to have a collective impact for the population and the lessons learned are incorporated into future decision-making.
- The MCOs Value-Based Payments (VBP) Plan submissions included a broad set of provider payment strategies intended to improve health care quality, outcomes, and efficiency by linking financial incentives to performance to further the outcomes of the pillars.
- The MCOs coordinated with a few of the first round of HealthCare Transformation Collaboratives (HTC) to assist the collaboratives in several areas such as care coordination, data sharing and community health workers. These collaboratives in coordination with the MCOs strive to address social determinates of health in their communities.
  More information about HTC is provided at ***https://www2.illinois.gov/hfs/Pages/HealthcareTransformation.aspx***.
- The MCOs annual Marketing, Outreach and Education Planning strategy was expanded to align with the outreach and community engagement strategies in order improve outcomes consistent with the Department's program goals. Strategies include:
  - Increasing patient self-care management including promoting primary care physician (PCP) selection to encourage preventative care, and appropriate health screenings.
  - Education and outreach initiatives that are Equity focused and designed to improve chronic disease management and behavioral health through health literacy and lifestyle programs focused on adults.
  - 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.
  - The MCOs plan for educating and increasing awareness of members and potential members in a community centric manner.

MCO Program Information

HealthChoice Illinois (HCI) **Enrollees:** Children and their parents, Affordable Care Act (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 2022 Enrollment**
	Aetna Better Health of Illinois	433,681
	Blue Cross Community Health Plans	696,001
	CountyCare Health Plan (Cook County only)	435,882
	MeridianHealth	872,894
	Molina Healthcare	335,678
	YouthCare	36,346
	Total HCI Health Plan Enrollment	**2,810,482**

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 2022 Enrollment**
	Aetna Better Health Inc.	15,907
	Blue Cross and Blue Shield of Illinois	22,512
	Humana Health Plan	16,331
	Meridian Complete Health Plan Inc.	17,236
	Molina Healthcare of Illinois	16,536
	Total MMAI Health Plan Enrollment	**88,522**

Total Managed Care Programs Participation	**Health Plans**	**June 2022 Enrollment**
HCI, MMAI	Aetna Better Health Inc.	449,588
HCI, MMAI	Blue Cross and Blue Shield of Illinois	718,513
HCI	CountyCare Health Plan	435,882
MMAI	Humana Health Plan	16,331
HCI, MMAI	Meridian Health Plan Inc.	926,476
HCI, MMAI	Molina Healthcare of Illinois Inc.	352,214
	Total Managed Care Programs Participation	**2,899,004**

LONG TERM SERVICES & SUPPORTS

LONG TERM SERVICES & SUPPORTS

This section provides an overview of the following components of the long term services & support program administered by the Department: Institutional, 1915(c) HCBS Waivers, and other community programs. For more information visit the Department's website at ***https://www. illinois.gov/hfs/MedicalProviders/ltss/Pages/default.aspx***. For information on LTSS in the managed care delivery system, see Care Coordination.

Institutional

The Department is responsible for the Medicaid Long Term Care (LTC) program. The mission is to ensure that the LTC services are appropriate for and meet the needs of customers, meet standards of quality, and are in compliance with Federal and State regulations. This section gives basic information about the LTC program and provides a more detailed summary of nursing facilities, which are overseen by both the Department and the Illinois Department of Public Health (IDPH).

There are four (4) basic types of institutional settings in the LTC program: 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):
- 672 NF
- Averaged 44,927 customers served in FY 2022

Specialized Mental Health Rehabilitation Facilities (SMHRFs)
- 23 SMHRFs
- Averaged 3,239 customers served in FY 2022

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)
- 194 ICF/IIDs
- Averaged 3,592 customers served in FY 2022

Medically Complex for the Developmentally Disabled Facilities (MC/DD)
- 10 MC/DDs
- Averaged 828 customers served in FY 2022

Licensed & Medicaid Certified LTC Beds

Fiscal Year 2022 Actual

Level of Care	Medicaid Certified Beds[1]	Licensed Beds[2]
Skilled Care	69,939	78,606
Specialized Mental Health Rehabilitation Facilities (SMHRFs)	0	4,263
Intermediate Care (ICF)	8,674	8,890
Intermediate Care for Individuals with Intellectual Disabilities	4,165	4,165
Skilled Care for Individuals with Intellectual Disabilities	936	936
Total	**83,714**	**96,860**

[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 Total Liability on Claims Received

Fiscal Year 2020 - 2022

Long Term Care - Total				
	FY 2020	**FY 2021**	**FY 2022**	**% Change FY 2020 to FY 2022**
Total Charges ($ Millions)	$1,458.71	$1,414.89	$1,161.90	-20.35%
Total HFS Liability[1] ($ Millions)	$690.69	$522.03	$414.39	-40.00%
Total Patient Days (Millions)	5.91	4.56	3.51	-40.61%
Weighted Average Rate[2] Per-Diem	$116.87	$114.48	$119.39	2.16%
Average Payment (Charge) Per-Diem[3]	$246.82	$310.28	$334.77	35.63%

[1]Reflects date of service liability and excludes capitated managed care reimbursements.
[2]Excludes patient contributions and third party payments.
[3]Geriatic only per diem for FY 2021 is $183.34. Chart includes Skilled, ICF, and SLP waiver.
Table prepared by Bureau of Long Term Care. Data Source: Bureau of Rate Development and Analysis

LTC Provider Assessment

The Provider Assessment Program (Program) was implemented in July 1991. The Program makes use of a provision in federal law that allows states to claim federal financial participation (FFP) on payments for NF and ICF/IID services that are funded from the receipts of taxes paid by NFs and ICF/IIDs. These funds have helped the Department provide critical institutional services to some of the neediest and most frail Illinoisans.

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. The new assessment is estimated to generate an additional $200 million in assessment collections and slightly more in federal revenues to support nursing facility payment reforms.

Funds generated by the Program are set forth below:

Fiscal Year	Nursing Facilities	ICF/IIDs
2019	$200	$17.6
2020	$168.7	$18.3
2021	$162.6	$20.2
2022	$160.6	$20.7

**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 IDPH are implemented. The Department works on a variety of billing issues such as ensuring that correct payments to providers are made by a system of ongoing pre-payment and post-payment review adjustments, providing billing assistance and information to providers, resolving billing discrepancies, and coordinating admissions information entry with the Department of Human Services (DHS). The Department further determines whether NFs meet the federal definition of an "Institution for Mental Diseases" for federal Medicaid claiming purposes.

Nursing Facility Reimbursement

In the HFS Departments 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 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 – New NFs do not have an established rate; they are given the median rate for their geographic area for the nursing and support components of the rate;
- Capital – NFs that have increased building costs by more than 10% in the form of improvements or additional capacity may request an adjustment to the capital component of their rate;
- Capital exceptions resulted in rate changes for 61 facilities in FY 2021;
- Initial Cost Reports – Under certain circumstances, recently enrolled NFs are required to file an initial cost report that may result in capital and/or support component revisions. Initial cost reports resulted in rate revisions for three (3) NFs.

Certification/Decertification of Long Term Care Facilities

During FY 2022 two (2) NFs closed. Both NFs closed due to financial hardship. There are no new NFs, SMHRFs or ICF/IIDs enrolled in the Medical Assistance Program during this same period.

Nursing Facility Rate Reform - Implemented July 1, 2022

Each year, HFS spends billions of dollars on nursing facility care for approximately 45,000 Medicaid customers. Medicaid pays for approximately 60% of all nursing facility days in Illinois and is the largest payor of days in both this state and across the nation. Our role as payor notwithstanding, HFS has a moral imperative to our customers to ensure that the services and care they receive in nursing facilities is safe, high quality and equitable.

HFS engaged with representatives of the nursing facility sector and legislative staff for over 24 months prior to reforming the nursing facility rate methodology used by the Medicaid program to pay for these services. Guiding principles were developed at the beginning of the process, which included:

- a transparent data driven approach with a sustained focus on completing the transition to Medicare's Patient Driven Payment Model (PDPM) nursing component,
- linking payment to performance and staffing levels,
- the need to incorporate lessons from the COVID pandemic, and
- streamlining the nursing home assessment to maximize federal revenue.

Adopting the Patient Driven Payment Model (PDPM) to improve payment accuracy.
The nursing component of the PDPM case mix classification system was adopted as the basis for calculation of the direct care rate, replacing use of the RUGS methodology. The PDPM will improve payment accuracy and appropriateness by focusing on the resident, rather than the volume of services provided. In addition, implementation of PDPM will stop the shift of unnecessary Medicaid payment for rehabilitation services, which are already funded separately by Medicare in most instances, towards residents with genuine Medicaid-financed needs.

Payment Incentives for Increased Staffing in Illinois Nursing Facilities:
Based on data reviewed during the reform process, Illinois has consistently ranked last among states in staffing as measured using the national Staff Time and Resource Intensity Verification (STRIVE) Project target staffing levels. Medicaid days are concentrated in facilities with high levels of Medicaid-enrolled residents as well as facilities with low staffing. Indeed, the higher the level of Medicaid utilization in a facility, the greater the likelihood that the facility is staffed below STRIVE target staffing levels – often far below that target.

Certified Nursing Assistant (CNA) shortages are the greatest factor in staffing shortages in Illinois nursing homes and explain Illinois' last place ranking on staffing nationally. Reducing CNA turnover is key to turning around staffing shortages, and this is most important in high-Medicaid homes.

The reformed reimbursement system allocates the majority of new funding for provider incentives intended to increase staffing levels. Over $300 million annually is paid through a tiered per diem add-on rate that starts at $9 per day for providers at 70% of the STRIVE staffing target, with a top level add-on of $38.68 for those at 125% of the STRIVE target.

Additionally, Illinois implemented a unique payment program that reimburses providers for the Medicaid portion of retention and promotion-based wage increments. Providers must establish wage scales paying at least an additional $1.50/hour during a CNA's second year and another $1/hour for each additional year of experience up to a maximum of +$6.50/hour. Promotion based increases will be reimbursed at $1.50/hour and may be stacked on top of the experience wage.

Quality and performance in Illinois SNF - Rewarding providers for quality care.
An analysis of the federally-published COMPARE website's 22 long- and short-stay quality measures showed that Illinois ranked in the bottom twenty states for nearly two-thirds of the measures, in the bottom ten states for nine of the measures, and last for three.

Increased staffing is expected to improve quality, but to further incentivize nursing facilities providing safe and high quality care, Illinois established a Quality Incentive Payment program that annually distributes $70 million based upon federally published Medicare STAR ratings. Providers must

receive at least a 2 STAR rating to receive funding. As provider Long Stay STAR ratings increase, they receive a higher proportion of the pooled funding.

Nursing Facility Assessment – Streamline and Increase the Funding Level
A major component of the reimbursement reform was to streamline the nursing facility assessment tax and create additional funding for the reforms. The licensed bed tax on nursing facilities was eliminated while the occupied bed tax was increased and restructured to maximize federal revenues. The assessment on occupied bed has been changed from a uniform tax of $6.07 per occupied non-Medicare bed, to a tax that varies based on volume of a provider's Medicaid days. The revised assessment provides over $400 million in new funding annually through increased tax and federal matching revenues on expenditures.

A much more detailed write-up on the rate reform process can be accessed on the HFS website at: ***A Comprehensive Review of Nursing Home Payment with Recommendations for Reform - HFS 09-30-21***

Eligibility Processing

Public Act 98-0104 requires the Department and DHS to:

- ***Complete LTC eligibility determinations in a timely manner.***
  DHS has continued their focus on LTC case processing and continual training. The 4th LTC hub in Anna was created on January 16, 2021. Both the LTC processing unit in Granite City and the MFO office in Anna continue to process applications and work on special projects. All of the DHS LTC offices contain specifically trained caseworkers to handle LTC processing of applications, admissions, redeterminations, and changes. Additionally, all of the DHS offices have moved from "task-based" to "facility-based" assignments. This change is intended to increase productivity and more evenly distribute workflow. DHS and the Department continue to utilize a database of pending LTC applications and admissions to ensure applications and admissions 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 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 the State's Integrated Eligibility System (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 Application for Benefit Eligibility (ABE). The ABE partner portal continues to be a great resource for providers. This provides an additional avenue for providers to upload redeterminations and verifications that are uploaded directly to an customer's/resident's case. Several updates have been made to IES which has improved application processing. Updates continue to IES and ABE in order to better serve customers and providers.

- ***Develop and implement a streamlined LTC application process.***
  DHS and the Department 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 an innovative model of community-based care that provides an alternative to traditional nursing facility care. The underlying principle behind PACE is that it is better for the well-being of seniors, and their families, when these individuals can be cared for in the community. The integration of comprehensive health care services through a PACE program is designed to meet the following objectives for seniors:

- Enhance their quality of life and autonomy;
- Maximize their dignity;
- Enable seniors to live in the community if medically and socially feasible; and
- Preserve and support the senior's family unit.

The PACE Organization becomes the sole source of services for seniors who choose to enroll in PACE. The PACE comprehensive service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the PACE interdisciplinary team. Services include, but are not limited to:

- Interdisciplinary assessment and treatment planning;
- All primary medical care provided by a PACE physician familiar with the history, needs and preferences of each senior, all specialty medical care, and all mental health care;
- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care;
- Diagnostic services, including laboratory, x-rays, and other necessary tests and procedures;
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, durable medical equipment, and medical supplies;
- Social services;
- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care;
- Home health care, personal care, homemaker and chore services;
- Restorative therapies;
- Emergency room services, acute inpatient hospital and nursing facility care when necessary;
- Respite care; and,
- Transportation for medical needs.

To be eligible for PACE the senior must meet these eligibility requirements:

- Be 55 years of age or older;
- Reside in the service area of the PACE organization,
- Meet the state definition for nursing facility level of care; and
- Be able to live safely in the community.

Illinois' Vision for PACE

The goals of the PACE vision are:

- to Improve health and wellness for qualifying individuals by expanding the long term care service continuum;
- customize solutions to meet the unique needs of communities beginning in five disproportionately impacted areas 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 other healthcare transformation initiatives.

In November 2021, the Department released a request for applications to select PACE organizations in established service areas.

In August 2022, the Department selected 8 PACE organizations across 5 geographic regions in the state:

- West Chicago
- South Chicago
- Southern Cook County
- Peoria
- East St. Louis

The Department is currently working with and continues to provide support to the selected PACE organizations as they pursue the federal CMS application and readiness review process. It is anticipated the PACE organizations will begin initial enrollment of participants June 2024.

Preadmission Screening and Resident Review (PASRR)

The Preadmission Screening and Resident Review (PASRR) process requires that all applicants to Medicaid-certified nursing facilities be given a preadmission, preliminary, assessment to determine whether they might have Serious Mental Illness (SMI) or an Intellectual Disability (ID) or Developmental Disability (DD). PASRR is an important tool for states to use in rebalancing services away from nursing facilities and towards supporting people in their homes, and to comply 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.

PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long term care. PASRR requires that Medicaid certified nursing facilities:

- Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID)
- Offered all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings)
- Provide all applicants the services they need in those settings

In 2021, the Department announced a Request for Proposals to procure a partner to develop and implement a redesign of the Illinois PASRR process which historically had been non-compliant. Throughout 2021 into early 2022, a new and improved process for preadmission screenings was developed in collaboration between HFS and its contracted partner (Maximus), the Department of Human Services Division of Developmental Disabilities and Division of Mental Health and the Department on Aging. Through the use of Maximus' AssessmentPro platform, great strides have taken place to ensure timeliness, accuracy, consistency and a more streamlined process to complete these assessments, known as Level I and Level II, for individuals with a suspicion of a severe mental illness or developmental disability. These assessments are completed by trained qualified staff who make recommendations on the appropriateness of nursing facility admissions or referrals to other community options.

In addition, the redesign was extended to include specialized assessments to individuals seeking admission to Specialized Mental Health Rehabilitation Facilities (SMHRFs) and Supportive Living Program (SLP) to ensure admission to these settings were the most appropriate or if the individual would benefit more from the "Front Door Diversion" program for potential SMHRF admission, other community services or from other Home and Community Based Services (HCBS) waivers.

The AssessmentPro platform went live for long term care providers on March 14, 2022. On April 18, 2022, the platform went live for SMHRF and SLP providers. The implementation of this new process has allowed Illinois to decrease the turnaround time to complete this assessment and connect individuals with long term services and supports more quickly and to improve ongoing care coordination efforts.

Home and Community-Based Services (HCBS) Waivers

In an effort to support independence and promote the health, safety and welfare of customers in their homes, the Department, in collaboration with the DOA and DHS and the University of Illinois, also offers care through nine (9) Home and Community-Based Services (HCBS) waiver programs. These waivers provide alternatives to Nursing Facility placement for customers allowing them to remain independent in their homes or community setting. The nine (9) HCBS waivers served 199,689 people in FY 2022. The Department, in its role as the single state Medicaid agency, provides administrative coordination, direction, oversight, program, fiscal, and quality monitoring for all nine (9) waivers.

HCBS waivers, authorized under 1915(c) of the Social Security Act, allow states to provide specialized, home or community-based long-term services and supports (LTSS) to individuals who would otherwise receive care in institutions. Each year, every waiver program must demonstrate that the cost of services for waiver participants is not more than the cost of serving the same population in an institution.

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

Waiver	Operating Agency
Persons with HIV or AIDS	Department of Human Services (DHS) Division of Rehabilitation Services (DRS)
Persons with Brain Injuries	DHS-DRS
Persons with Disabilities	DHS-DRS
Adults with Developmental Disabilities	DHS-Division of Developmental Disabilities (DDD)
Children and Young Adults with Developmental Disabilities - Support	DHS-DDD
Children and Young Adults with Developmental Disabilities-Residential	DHS-DDD
Persons who are Elderly	Department on Aging (DOA)
Medically Fragile, Technology Dependent Children	University of Illinois Chicago, Division of Specialized Care for Children (DSCC)
Supportive Living Program	HFS

See ***https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx*** for detailed information on each waiver.

On January 16, 2014, the federal CMS published final regulations (42 CFR 441. 301(c)) pertaining to Home and Community-Based Services (HCBS). Under the regulations, all settings that provide HCBS must demonstrate the characteristics of a community-based setting wherein individuals receiving HCBS services and have the same access to their communities as individuals without HCBS. All states must ensure HCBS provider setting compliance with Federal requirements by March 17, 2023, for continued HCBS funding. States are also required to submit a Statewide Transition Plan (STP) that described to CMS their plans for transitioning to compliance, including within their plans an assessment of the extent to which a state's regulations, standards, policies, licensing requirements, and other prover requirements are aligned with the final regulations pertaining to HCBS provider settings.

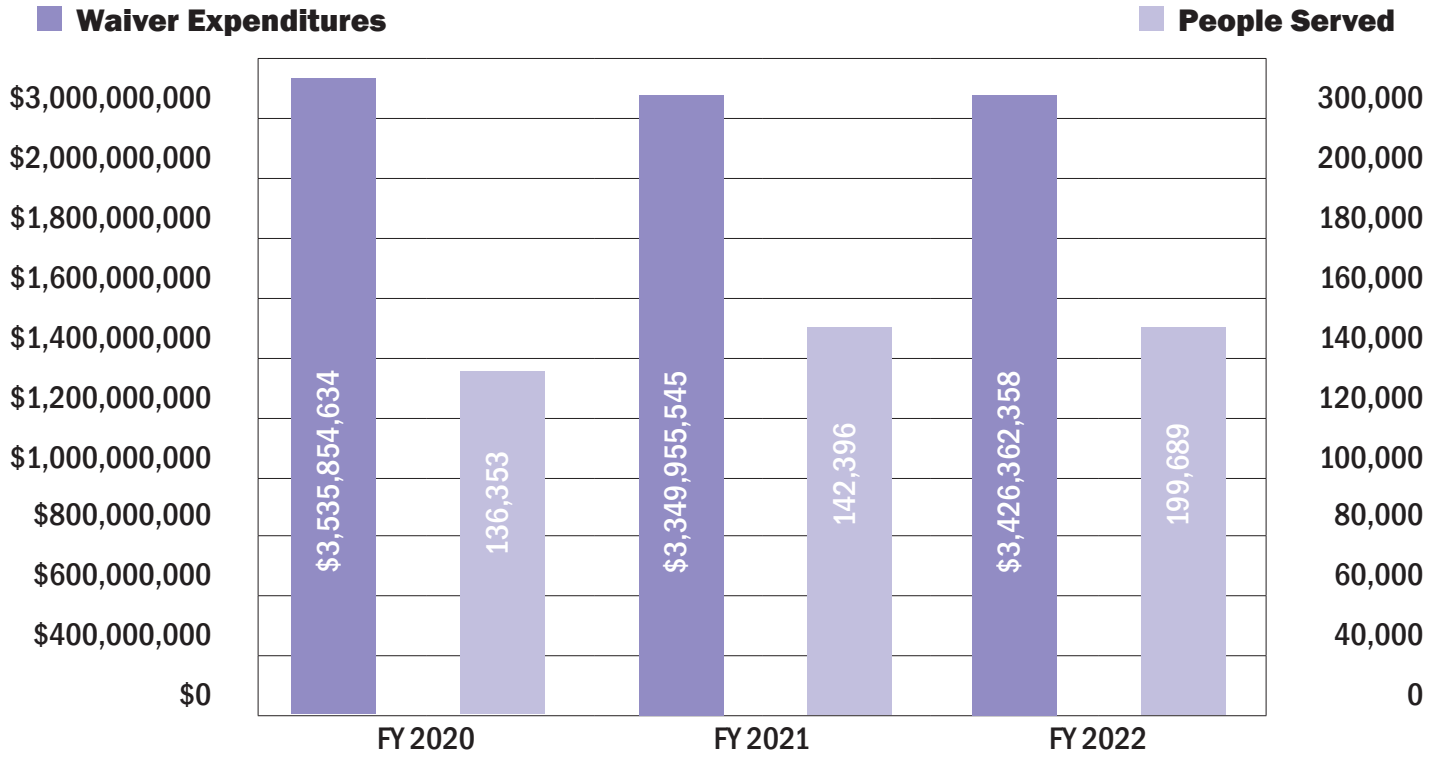
Advancing Our Quality Pillars

Community-Based Services and Supports

Supporting the Department Quality Pillar of expanding Community-Based Services and Supports, the Department has collaborated with the State's HCBS waiver operating agencies during the transition period to enhance non-disability settings options, and to provide opportunities for competitive-integrated employment, person-centered services based on individual preference and need, and opportunities for individual access to the community. The Department presented the final STP draft for public comment in September 2022 and subsequently uploaded feedback to public comments. A copy of the Public Notice regarding the State's response to public comments is located at: ***https://www2.illinois.gov/hfs/sitecollectiondocuments/11182022publicnoticestateresponsetofinalstatewidetransitionplanstp.pdf***. After completing minor revisions based on public comments, the STP was

submitted to CMS for final approval in. The Department received notification from CMS of the approval of the State's STP on February 15, 2023. CMS' Approval Letter and the approved Final STP may be accessed at: ***https://www2.illinois.gov/hfs/MedicalClients/HCBS/Transition/Pages/TransitionPlan.aspx***.

Waiver Expenditures & Beneficiaries Served



Note: All data was compiled from the Enterprise Data Warehouse (EDW). FY 2022 figures are preliminary and are expected to increase due to waiver expenditure data reported up to 18 months after expenditures are incurred. In 2022, enrollment grew as expected due to customers remaining on the program during the COVID-19 pandemic. Per federal requirements customers can continue to receive services during the pandemic and will not disenroll from the program. Overall expenditures increased by $76 million. This is due to an increase in service utilization across all waivers during the COVID-19 pandemic as customers began to allow workers back into their homes; it is also due to rate increases that were implemented across several services during the COVID-10 pandemic.

Quality Assurance

In collaboration with the waiver operating agencies,the Department operates a formal, comprehensive quality assurance system to ensure the HCBS waivers support the Departments goal to maximize quality of life, functional independence, health, safety, and the well-being of Medicaid waiver participants. Following rigorous federal requirements, the continuous HFS quality improvement process of discovery, remediation and system improvement promotes the health, safety and welfare of participants by monitoring performance measures, analyzing patterns and trends, and establishing systemic enhancements. The Department holds quarterly meetings with the waiver operating agencies and MCOs on each waiver's quality improvement system and works closely with them, the federal government and, for some of the waivers, an Department contracted vendor.

LTC Rebalancing

The purpose of the Money Follows the Person (MFP) program is to increase the use of home and community-based services rather than institutional services and supports. The MFP program enables Medicaid-eligible customers to receive long term supports necessary to reside in settings of their choice. This means more customers will have the opportunity to transition from an institution to a community setting or to remain in the community longer avoiding/delaying an institutional admission.

In March of 2022, a Notice of Funding Opportunity (NOFO) was announced by federal CMS to expand the MFP Demonstration. States not currently participating in the MFP Demonstration were invited to apply for the NOFO. In May 2022, the Department applied for this opportunity. Approved applicants were eligible to receive a funding grant of up to $5M to support the efforts of a 16-month Planning Phase.

In September 2022, federal CMS announced that Illinois was one of five states selected to receive a funding grant and received an award of nearly $4M. In addition, certain expenditures are eligible for an enhanced Federal Medicaid Assistance Percentage (FMAP) match under the MFP program.

The purpose of the Planning Phase is to assess; long term services and supports currently available, what and where need exists, and the ability to provide those services to eligible customers. HFS in collaboration with DHS, DOA and the Department of Housing Development Authority (IHDA), advocates, potential participants, stakeholders, and other interested parties are currently in the process of analyzing the needs and resources that will be necessary for implementation. Furthermore, during this Planning Phase the Department will seek to enhance quality improvement systems, develop a service provider network, expand workforce recruitment and retention strategies, and further refine transition services.

Also, during the Planning Phase, HFS will seek federal CMS approval of an Operational Protocol to carry out the objectives of the MFP Demonstration. Approval of this protocol will allow the Department to move into an Implementation Phase. The Implementation Phase will be the beginning of transitioning eligible customers and providing long term services and support under the MFP program. To help support future efforts, the Department is eligible to receive additional grant funding of up to $5M per year for the next 4 years to meet the objectives of the MFP Demonstration which has received federal funding through 2027.

The Department has convened the Community Integration Subcommittee of the Medicaid Advisory Committee (MAC). The goal of the subcommittee is to provide recommendations to the MAC that will increase the number of individuals with disabilities in the community who receive long term services and supports.

HOSPITAL SERVICES

HOSPITAL PROVIDER REIMBURSEMENT

Total overall spending on hospital claims of $4.8B in FY 2022 was a slight increase over the $4.68B spent in FY 2021. That increase is due to an increase in outpatient services and spending as inpatient utilization and spending was down in FY 2022.

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 individuals covered under the FFS Program, as well as a MCO plans.

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.

251 Cost-reporting hospitals participated in the Illinois Medicaid program in FY 2022

Advancing Our Quality Pillars

Maternal and Child Health

Inpatient Hospital Services - General Revenue Fund (GRF)

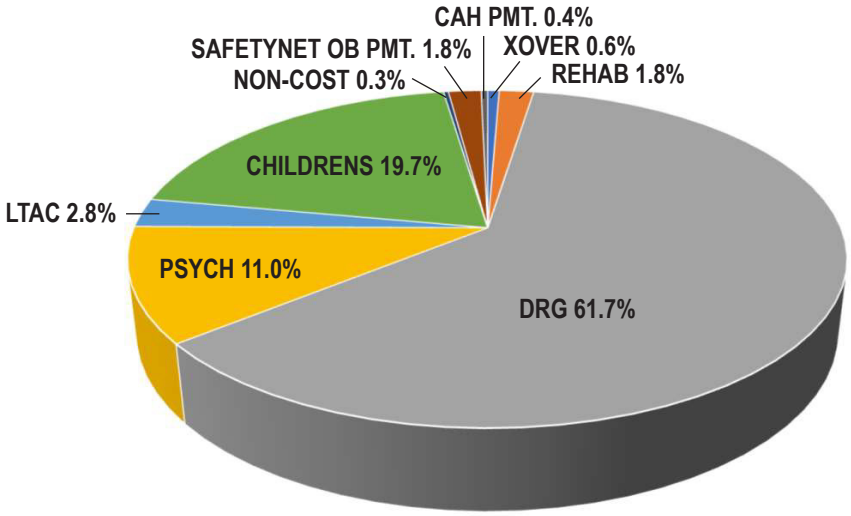
Inpatient hospital claims consist of acuity-based groupings, called All Patient Refined Diagnosis Related Groups (APR-DRG) with several specialized claims based add-ons, including disproportionate share, safety-net, psychiatric, Medicaid Percentage Adjustment and Medicaid High Volume Adjustment. Some types of claims are excluded from APR-DRG and continue to be paid on a per diem basis, including psychiatric and rehabilitation hospital claims and services provided by long-term acute care (LTAC) hospitals and non-cost reporting hospitals.

Total FY 2022 hospital inpatient liability, including payments for both FFS and Encounter claims totaled $2.852 billion, down 1% from the $2.886 billion spent in FY 2021. This corresponds with a 3% decrease in total inpatient admissions but also includes the repeal of the 3.5% SMART Act reductions that were eliminated on hospital claims effective July 1, 2021. To advance the quality pillar 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, 61.7% of the $2.852 billion in state FY 2022 hospital inpatient payments were made in pursuant to the APR-DRG based system, resulting in a slight decrease from the 63.4% in FY 2021.

2022 GRF Hospital Inpatient Spending - $2.8 Billion

Inpatient FY 2022 % of Total Payments



Ambulatory Care Services

The EAPG system works much like a DRG system on the inpatient side, assigning like procedure codes to an EAPG group and assigning relative weights to the EAPG groups based on national averages of resource consumption to provide the services.

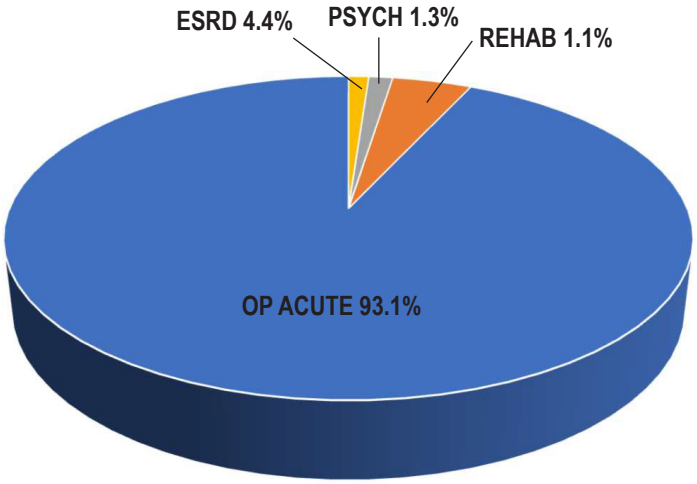
This system allows hospitals to be paid for multiple procedures on one claim and also incorporates discounting and consolidation of payments when appropriate.

Total spending on outpatient claims paid via the EAPG system rose 12% to $2 billion in 2022 over the $1.8 billion in 2021. That spending increase was accompanied by a 12% increase in the number of outpatient services provided as well, from 7.4 million services in 2021 to 8.2 million in 2022.

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

2022 GRF Hospital Outpatient Spending - $2.0 Billion

Outpatient FY 2022 % of Total Payments



Disproportionate Share Hospitals

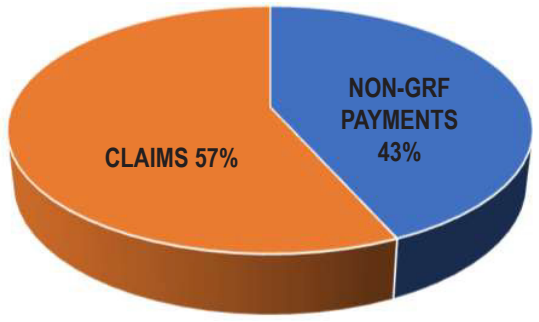
Federal law requires hospitals that serve a disproportionate number of low-income patients with special needs be given an appropriate increase in their inpatient rate or payment amount. Additionally, states are federally mandated to provide the increased payment to any hospital whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate or whose low income utilization rate exceeds 25%. In FY 2022, the Department expended $285.9 million of its federal Disproportionate Share Hospital (DSH) allotment, which equated to about $500.2 million in total spending including state matching funds.

The following numbers of hospitals qualified for DSH in rate year 2022: 84 private (non-governmental) hospitals, including 25 which received DSH payments because they were within the federal guidelines set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1993; two (2) State-operated psychiatric hospitals qualified for DSH because their low income utilization rate exceeded 25%; and government-owned hospitals (University of Illinois Hospital and Cook County Hospitals and Health Systems). As federally-required, the Department performs an annual OBRA calculation to ensure that spending to each hospital does not exceed the combined costs of services to the Medicaid and uninsured populations.

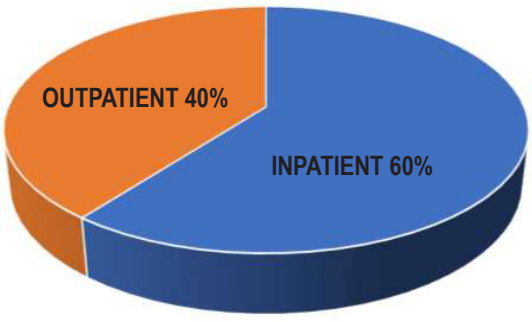
Non-GRF Funded Hospital Payments

The Hospital Provider Assessment Program was originally implemented in July 1991 and has been changed somewhat since that time. In accordance with Public Acts 95-0859, 97-0688, and 98-0104, 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 $3.7 billion in payments were made to the hospitals in FY 2022 through both FFS Plan and payments made through the HCI MCO Plans.

Total FY 2022 Hospital NON -GRF Payments vs Claims



FY 2022 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 to be 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 2022 through July 2022, the amount of actual payments over the modeled amount was $250,000,119. Therefore, the tax adjustment was an increase of $96,325,046. See details below:

Tax Increase Calculations for 07/01/2022

Actual Payments 01/01/2022 – 06/30/2022	$1,557,609,183
Less Modeled Payments	$1,307,609,064
Payment in Excess	$250,000,119
	x .3853
Tax Increase	$96,325,046

Aggregate payment amounts for the period of July 1, 2022 through December 31, 2022 totaled $405 million more than modeled. To fund these payments, the tax adjustment implemented January 2023 of $155,985,867 is detailed below.:

Tax Increase Calculations for 01/01/2023

Actual Payments 07/01/2022 – 12/31/2022	$1,711,972,500
Less Modeled Payments	$1,307,129,864
Payment in Excess	$404,842,636
	x .3853
Tax Increase	$155,985,867

Utilization Review & Quality Assurance

State Medicaid agencies are required to provide utilization review and quality assurance review in the inpatient hospital setting for services provided to FFS Plan customers. The Department contracts with a federally designated quality improvement organization-like entity to provide these services. In FY 2022, non-certification of medically unnecessary services resulted in direct cost savings of $2.41 million for the Department.

PHARMACY SERVICES

PHARMACY SERVICES

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

The Department controls access to certain reimbursable drugs via a prior authorization process, and regularly evaluates which drugs should be subject to prior approval based upon the relative safety, efficacy, and costs for covered medications. The Drugs and Therapeutics Advisory Board is comprised of nine clinicians that have been appointed by the Governor to provide clinical reviews and advisory recommendations regarding which drugs should require prior authorization. This panel meets quarterly for the purpose of conducting drug reviews.

The Department has increased the professional dispensing fee to Critical Access Pharmacies through our CAP Program, this helps to increase the viability of smaller pharmacies and increases access to care.

The Department requires MCOs to cover only drugs made by manufacturers who participate in the federal Medicaid drug rebate program.

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 University of Illinois Chicago's College of Pharmacy performs the clinical analysis for each therapeutic class of drug under review and prepares monographs. The Department develops recommendations based on efficacy and safety data contained in the clinical monographs along with the net cost data. The Drugs and Therapeutics Advisory Board reviews the Department's PDL proposals in each therapeutic class for clinical soundness. The Department only covers medications made by manufacturers who are enrolled with the federal drug rebate program. Through the PDL process, the Department 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 FY 2022, the Department collected approximately $191.2 million in State supplemental rebates from drug manufacturers. In addition to supplemental drug rebates, the Department collected $52 million in rebates on blood glucose testing equipment and 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. Critical Access Pharmacies for purposes of the professional dispensing fee are identified as pharmacies physically located within Illinois in counties with less than 50,000 residents; and whose owner(s) do not have ownership or controlling interest in ten (10) or more pharmacies; and which are brick and mortar, meaning the pharmacy location is open to the public, customers present at the pharmacy to fill prescriptions, and 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 prior approval. Requiring prior approval allows additional controls to be employed, and to ensure appropriate therapy is being prescribed. In MCO this oversight occurs through the plans' required customer restriction program where, at a minimum, the MCO must restrict an customer for a reasonable period to a designated PCP or provider of pharmacy services when:

(1) the Department indicates the enrollee was included in the Department's Recipient Restriction Program pursuant to 89 Ill. Admin. Code 120.80 prior to enrollment with MCO; 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).

While the FFS program also utilizes the above-mentioned Recipient Restriction Program, they add an additional narcotic edit, whereas the Department controls access to any controlled pain medication for customer with a clinical profile that indicates the member's utilization needs should be managed closely. All prior approval requests for customers with such a clinical profile result in a comprehensive review of the customers Medicaid prescription history, as well those prescriptions that are reported through the Illinois Prescription Monitoring Program.

In addition, pharmacy programs within Illinois Medicaid must have a drug utilization review (DUR) program which shall include processes, procedures, and coverage criteria to include a prospective review process for all drugs prior to dispensing, all non-formulary drug requests, and a retrospective DUR process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse.

Specialty Drug Use

The Department has implemented utilization controls, including prior approval requirements, on several specialty drugs in the following classes: immunosuppressive agents, erythropoietin stimulating agents, HIV medications, hepatitis C agents, cystic fibrosis medications, oncology agents, and medications for orphan diseases. The goals of the specialty drug utilization controls are to encourage the use of the most cost-effective medications where clinically appropriate and to ensure utilization is consistent with treatment guidelines.

Four Prescription Policy

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, quantity and duration of therapy. Providers review their patients' entire medication regimen and, where possible and clinically appropriate, reduce duplication, unnecessary medications, and polypharmacy. The FFS plan has a Four Prescription Policy Program, which identified opportunities to improve efficacious drug therapy. Additional information on the Four Prescription Policy is available on the Department's website at ***https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/FourPrescriptionPolicy.aspx***.

Hemophilia Care Management Program

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

Mental Health Services

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

Pathways To Success
The Department continued its efforts to address this issue by furthering its focus on the service delivery system for children with complex behavioral health needs through the development of the Pathways to Success Program that will provide enhanced care coordination through High-Fidelity Wraparound and Intensive Care Coordination as well as additional home and community based services including Intensive Home-Based, Therapeutic Mentoring, Respite, Family Peer Support and Therapeutic and Individual Support Services.

In FY 2022, the Department secured approval from federal CMS to implement the program and moved forward with implementation activities including selecting qualified Care Coordination and Support Organizations (CCSOs) to provide High-Fidelity Wraparound, Intensive Care Coordination, Therapeutic and Individual Support Services as well as Mobile Crisis Response in newly organized Designated Service Areas (DSAs) across the state.

Additionally, in partnership with the University of Illinois – Urbana Champaign, School of Social Work's Provider Assistance and Training Hub and national experts, the Department developed training curricula for each of the Pathways to Success services. The Department began trainings early FY 2023, with children beginning to be enrolled and services started.

Integrated Assessment and Treatment Plan
To further support the implementation of the standardized Integrated Assessment and Treatment Plan (IATP), the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) team has begun tracking crucial provider-driven data for FY 2022. In FY 2022, approximately 3,452 new providers received training on the IM+CANS model, with 6,457 current users. The Department also launched the IM+CANS Provider Workgroup to gather information from providers about how to improve the implementation process for the IM+CANS and to discuss upgrades to the IM+CANS Provider Portal. The IM+CANS Provider Portal was launched to all providers on January 1, 2021. For FY 2022, 143,887 distinct IM+CANS have been entered into the Provider Portal. The IM+CANS team will continue to monitor provider response and track data to ensure that the IM+CANS tool and platform are supporting the departments behavioral health-related mission and goals for all of our Illinois customers.

Mobile Crisis Response Services

The Children's Mental Health Act of 2003 (***Public Act 93-0495***) required the Department to develop protocols for screening and assessing children and youth prior to any admission to an inpatient hospital that is to be funded by the State. In response to this requirement, the Department, in collaboration with DCFS and DHS, developed the Screening, Assessment and Support Services (SASS) program.

Since July 1, 2004, the SASS program has operated as a single, state-wide system serving children and youth who are experiencing a mental health crisis and whose care requires public funding from the Department, DCFS, or DHS. SASS operates 24 hours a day, 7 days a week for children and youth in the fee for service delivery system. SASS features a centralized point of intake known as the Crisis and Referral Entry System (CARES) line. The CARES line receives referrals for children and youth in crisis, determines whether the level of acuity meets the threshold of crisis, and refers the call to the most appropriate community resource, which may include the dispatch of a SASS crisis responder. In FY 2022, the CARES line received 121,936 calls, of which 118,767 were due to a crisis.

In FY 2022, there were 2,951 unique children/youth who experienced one (1) or more crisis events in the FFS plan.

In FY 2022, the MCO system responded to 13,620 unique children/youth in crisis.

Following the crisis event, SASS crisis workers provide crisis intervention services and assist in determining the clinically appropriate level of care for the youth – such as referrals to community-based services, providing case management and treatment services, or, when appropriate, facilitating inpatient psychiatric hospitalization.

As the State's Medicaid infrastructure began to evolve through the introduction of care coordination and MCO service delivery systems, the State's approach to crisis response has also evolved. Many of the children and youth traditionally served by the SASS program are now being served by Mobile Crisis Response (MCR) programs, which are administered and funded by the various Department contracted MCOs. MCR continues to feature centralized intake via the CARES line and access to face-to-face crisis intervention services. The Departments actively work with contracted MCO entities to ensure coordination and continuity of care across the crisis response systems. Additionally, the Department has integrated MCR into the Pathways to Success program to further solidify the connection between care coordination and crisis services specifically for youth with the most complex behavioral health needs.

Violence Prevention – Community Support Team

To assist in offering enhanced services to individuals who have experienced community violence, particularly involving firearms, the Department launched a new service known as Violence Prevention – Community Support Team. This service pairs clinical staff with peer support workers who have had lived experience with various forms of community and firearm violence in a team approach. The team works directly with individuals who have experienced community and firearm violence to address their mental health concerns and assist them in functioning better within their communities.

Family Support Program

Public Act 99-0479 20 ILCS 1705/7.1 required the transition of what was historically known as the Individual Care Grant (ICG) program from DHS – Division of Mental Health (DHS-DMH) to the Department. In FY 2018, the program was revamped to better reflect the Department's behavioral health policies through the promulgation of Title 89 Illinois Administrative Code, Part 139 (Rule 139), transitioning what had been the ICG program to the Family Support Program (FSP). Rule 139 redefined eligibility criteria for entering the program, making services more readily available to a wider array of Illinois youth. Rule 139 also introduced utilization management components to ensure those enrolled in FSP are receiving the clinically appropriate level of care. In FY 2022, the Department continued to provide a coordinated system of community-based and residential treatment services that vary in scope and intensity to meet the needs of youth in the program. The Department also increased the age limit of the program from up to the age of 21 to age 26. This increased age range will assist older youth in transitioning to adult services without interruption in their care when they turn 21. In FY 2022, FSP served 712 youth.

Specialized Family Support Program (SFSP)

The Specialized Family Support Program (SFSP) was implemented pursuant to the Custody Relinquishment Prevention Act 20 ILCS 540/, effective January 1, 2015. It is a collaborative effort between the Department and DCFS, DHS, 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.

Through leveraging these existing state resources, altering key program policies to accommodate the specialized needs of this population, and providing access to community stabilization services, SFSP is now actively assessing and linking youth at risk of custody relinquishment and their families to services through the most appropriate State agency. SFSP has been implemented consistent with the Department's efforts related to the behavioral health transformation, including the implementation of the MCO delivery system. In FY 2022 five (5) youth were referred to the SFSP.

Integrated Care for Kids (InCK) Model Grant

Late in FY 2019, the Department partnered with two provider organizations, Ann & Robert H. Lurie Children's Hospital of Chicago and Egyptian Health Department, to apply for the Integrated Care for Kids (InCK) Model grant. The InCK Model is a child-centric service system and state payment model that seeks to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. The Department and provider organizations were notified in December 2019 that both organizations had been awarded this 7-year federal grant opportunity. Implementation of the grant began with the establishment of Interagency Agreements and further refinement of the Alternative Payment Models to help drive innovation and improved outcomes for participants in the grant funded services.

In FY 2022, the Department and the provider organizations began preparations to complete the Planning Phase of the grant and to move into the Demonstration Phase and began offering grant supported services in January 2022.

From July 2021 up until January 2022, Lurie Children's Hospital focused on building their provider network and infrastructure by hosting regular partnership council and committee meetings, negotiating agreements with MCOs, launching their InCK website, and hiring provider network liaisons and Resource Coordinators. After successful implementation efforts, they completed 314 needs assessments by the end of FY 2022.

Egyptian Health Department also completed implementation activities before beginning to provide services in FY 2022 including developing a referral platform and the care management system, training 11 Service Integration Coordinators (SICs) and other frontline staff on case management roles, care coordination platforms, and available resources and clinical therapies for children, and participating in quarterly virtual meetings, created sub-committees dedicated to community engagement, compliance, clinical, and marketing/promotions. After successful implementation efforts, they completed 354 needs assessments by the end of FY 2022.

The University of Illinois' Office of Medicaid innovation (OMI) has also played a key role under this grant. OMI established data flow between the providers and the Department, including monthly and annual requirements as it pertains to claims and attribution files. OMI has also continued to work with the providers to develop Alternative Payment Models (APM) to support ongoing InCK services.

Certified Community Behavioral Health Clinics (CCBHC)

With the passage of ***Public Act 102–0043*** the Department was requested to establish a program for the implementation of CCBHCs effective January 1, 2022. CCBHC is a federally defined provider type in Medicaid, designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations.

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 provide a comprehensive collection of services needed to create access, stabilize people in crisis and provide the necessary treatment for those with the most serious, complex mental illnesses and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration.

As part of the planned implementation, HFS is providing 'CCBHC Bridge funding' in the form of state grants to eligible CCBHC providers to sustain operations as the state develops the CCBHC program. In addition, HFS is working with its sister state agencies to develop a comprehensive approach to establish CCBHC as a viable provider of comprehensive services within the Medicaid program.

Psychiatric Consultation Phone Line — Illinois DocAssist

The Illinois DocAssist Program (DocAssist) is a Statewide psychiatric consultation and training service for PCPs or practitioners serving Medicaid enrolled children and youth under age 21 in the FFS and MCO plans delivery systems. DocAssist is staffed by child and adolescent psychiatrists and allied medical professionals from the University of Illinois Chicago, College of Pharmacy and College of Medicine – Department of Psychiatry. DocAssist provides consultation services to assist front-line PCPs in meeting the need for early intervention for children and youth. In addition to providing direct phone consultation, DocAssist Supports providers by offering targeted training and educational seminars on common child and adolescent behavioral health issues and makes resources available through its website: ***Illinois DocAssist***.

SUBSTANCE USE DISORDER SERVICES

Centers for Medicare and Medicaid Services (CMS) Substance Use Disorder Treatment

Capacity Planning Grant - Illinois SUPPORT Initiative

The Department continued implementation of a $4.5 million grant award from federal CMS for the Illinois SUPPORT Act: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity Initiative.

The Illinois SUPPORT planning grant, awarded in September 2019, focused on increasing provider capacity and patient access to office-based medication assisted treatment (MAT), for Medicaid eligible individuals as part of a comprehensive, public health approach to addressing the opioid crisis. To accomplish the goal of improving treatment capacity, HFS partnered with Cook County Health (CCH) and Southern Illinois Health (SIH) to complete the following activities under the grant: 1) Conducting a data-driven needs assessments for substance use disorder and opioid use disorder (OUD) for Medicaid customers; 2) Increased training for prescribers of MAT; 3) Expanded technical assistance for prescriber through in-person and web-based platforms; and 4) Improve the accuracy of information collected for providers certified to prescribe MAT and which providers are actively prescribing MAT.

In August 2021, Illinois applied to CMS for and was one of five states awarded a 36-month post planning demonstration grant. During the demonstration, Illinois will be eligible for enhanced FMAP, up to 80% for all eligible Medicaid services related to Medication Assisted Treatments for Opioid Use Disorders and treatment of other substance use disorder. To receive the enhanced FMAP, Illinois will demonstrate an increase in Medicaid expenditures related to all Substance Use Disorder (SUD) treatment services during each quarter of the demonstration. Illinois is working with CMS to determine the baseline for expenditure that will be eligible for the enhanced match. The baseline will be equal to 25% of all Medicaid eligible expenditures related to the treatment of opioid use disorders and other substance use disorder that occurred during FY 2018.

During FY 2022 the SUPPORT Grant partners have facilitated OUD/SUD Training and TA activities resulting in:

- Almost 2,100 professionals participating in teaching activities including presentations, workshops, lectures, problem-based learning;
- 239 prescribers participated and received experiential training (shadowing, reverse shadowing, observation);
- 129 prescribers participated in Technical Assistance (remote consultation, coaching and mentoring);
- 34 clinicians began prescribing buprenorphine for OUD (A direct result of SUPPORT Act Training and Technical assistance).

1115 Waiver Illinois Behavioral Health Transformation

In May 2018, the Department received approval of its 1115 Waiver request. This waiver included pilot designed to better serve Medicaid customers in need of behavioral health services. The 1115 SUD waiver approval period is from July 1, 2018 through June 30, 2023.

Beginning July 1, 2018, the Department, in partnership with DHS/SUPR, implemented four SUD pilots:

- Residential/Inpatient SUD Treatment in an IMD;
- Case Management for 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 currently licensed by SUPR, which are not otherwise matchable expenditures under section 1903 of the Social Security Act. Providers of Clinically Managed Residential Withdrawal Management must have the ability to coordinate or provide MAT for those patients who need this regimen of care.

In the first four years of the 1115 SUD demonstration (July 1, 2018 through June 30, 2022) there were an estimated:

- 2706 individuals who received treatment through the SUD residential IMD Pilot;
- 1054 individuals who were enrolled in SUD case management services;
- 47 individuals enrolled in Peer Recovery Support Pilot;
- 1 individual enrolled in the Clinical Withdrawal Management Pilot.

OTHER COMMUNITY SERVICES & INITIATIVES

OTHER COMMUNITY SERVICES & INITIATIVES

Maternal and Child Health Promotion

Advancing Our Quality Pillars

- Equity
- Maternal and Child Health

The Department is committed to improving the health of women and children. The Department serves as an advocate in promoting wellness through a continuum of comprehensive health care programs that address such issues as social emotional development, immunizations, lead screening, and family case management. Improving the health status of mothers and children can be achieved through education, prevention, and partnerships with other programs. The 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. More information on the programs offered by HFS and HFS requirements for MCOs can be found at: ***https://www2.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/report.aspx***.

The Department identified Maternal and Child Health as one of the pillars in the P4P and P4R initiatives in 2020. In addition, Illinois became 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 births of over 80,000 babies are covered by the Department every year. See the perinatal report issued by the Department and IDPH on the status of prenatal and perinatal health care services: ***https://www2.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/report.aspx***. The Department continues to assess maternal/child health outcomes and continues to make improving maternal health and birth outcomes a priority in Illinois.

The Department is working to establish new covered services and provider types, including doulas, lactation consultants, community health workers and certified professional midwives.

In addition, the Department is implementing a new Medicaid partial benefit Family Planning Program.

The department is working towards significantly increased cross-agency collaboration with DPH to improve maternal health outcomes for Medicaid customers.

Local Health Department Partnerships

The Department is re-starting the Medicaid administrative claiming for MCH 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 Departments Quality Pillars, specifically MCH. The Department advances the MCH Pillar by enabling LHDs to claim additional reimbursemnt for MCH costs.

Federal Medicaid allows LHDs to recoup a portion of their actual costs for MCH services for Medicaid-enrolled clients, if their costs are greater than their DHS grants. This is an opportunity for LHDs to expand their funding for services that they already provide – participation is not mandatory.

The Department has developed a new Claiming Guide and Intergovernmental Agreement (IGA) and has held training webinars for interested LHDs. IGAs will be sent in early 2023 to LHDs for participation in this program.

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, prior approval of services, ongoing reporting to the Department and quality assurance monitoring. In addition, DentaQuest provides services aimed at ensuring participant access to care for medically necessary dental services such as provider recruitment and training, 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. Link to Fee Schedule - ***https://www2.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Dental.aspx***.

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

FY 2022 Dental Payments

	Number of Individuals	Dental Services	Payments
Individuals under 21	71,116	598,459	$15.6 million
Individuals 21 and over	70,749	506,929	$17.8 million
Total	**141,865**	**1,105,388**	**$33.4 million**

For more information regarding the HFS Dental Program, see the Department's Dental Program webpage at ***https://www.illinois.gov/hfs/MedicalProviders/Dental/Pages/default.aspx*** or contact DentaQuest at ***www.DentaQuest.com*** or 1-888-286-2447 (toll free).

Bright Smiles from Birth Program

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 federally qualified health centers 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 and 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). This reimbursement allows students to receive medical and behavioral health care in their community and increases the availability of access to care. For more information visit: ***SBHS website***.

Advancing Our Quality Pillars

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

Approximately 171,000 children received direct medical services through the school-based program during FY 2022. LEAs were reimbursed over $98.8 million for their costs to provide these services, as well as about $66.6 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 a number of factors in determining the selection of providers for audit, including, but not limited to, data analysis; fraud and abuse trends; identified vulnerabilities of the 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 for Public Integrity offers states the use of UPIC auditors to perform targeted audits at no cost to the state. Both the internal and external audits may result in recoupment of overpayments, the entry of integrity agreements, termination from the program, or referral to law enforcement.

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 patient that outweighs the potential benefit of the service. Medically unnecessary care is identified when the care provided to the patient is not needed or is in excess of the patient's

needs. Grossly inferior quality of care is identified when flagrantly poor care is provided to a patient. 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 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; case closure with minor deficiencies identified and sending a letter to the provider identifying these minor concerns; or a referral to an OIG physician consultant for further review of potentially serious concerns. The physician consultant, in turn, may recommend a letter to the provider outlining quality of care concerns and corrective action recommendations, if they only identify minor concerns. For more serious quality of care concerns, OIG requires the provider attend a Medical Quality Review Committee (MQRC) meeting to discuss the care provided and to clarify or discuss the concerns identified in the review. The MQRC consists 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 (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 before they receive 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, the 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 Bureau of Medicaid Integrity work with the 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 often place the at-risk recipients into a case management/care coordination system, referred to as the Recipient Restriction/Lock-In Program, for 12 months. At the end of the 12-month restriction period the recipient's usage is re-evaluated. The restriction is released if utilization of services is appropriate or continued for an additional 24 months if overutilization has continued.

Bureau of Investigations

New Provider Verification: The Bureau of Investigations' (BOI) New Provider Verification Unit (NPV) reviews certain providers' enrollment applications for concerns such as past convictions or sanctions. NPV gathers additional information and bases on its findings 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 serves as the central fraud intake unit for OIG. The Complaint Intake Unit 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.

Research is conducted on fraud allegations by accessing multiple 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 the 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. During this fiscal year, the Bureau continued a transition to focus resources on the investigation of Medicaid providers. In the course of its investigations, BOI works with the State Police's 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 through false acts or omissions to obtain services or payments for which they were not eligible. These investigations may result in the identification of overpayments, closure of the medical assistance case, or prosecution by state and federal agencies.

Bureau of Fraud Science and Technology (BFST)

Dynamic Network Analysis: The OIG Bureau of Fraud Science & Technology (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. These reports serve as a "one-stop shop" for OIG staff's programmatic work, including audits, investigations, claim review, and peer review. 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 all providers by their provider type in multi-dimensional views. This allows the user to scan all 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 use is a matter of national health concern and can be considered an epidemic due to misuse and overdose. 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 after validating morphine milligram equivalents (MME) outcomes. The opioid dashboard module allows users to visualize usage trends of opioid related drugs by MME level for the past five years. Management users can choose either a view of overall

statistics or for a specific opioid. 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 formulas 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. Risk scores are derived from statistical approaches, including network cluster analysis, and supervised, unsupervised, and semi-supervised learning. Each approach provides an individual risk score. The risk scores are combined to create the overall risk score for a provider. The predictive models generate a ranking for all providers. 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, Enterprise Data Warehouse, federal 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 Departments Medical programs. OIG's Bureau of Internal Affairs investigates misconduct by the Department and DoA employees, contractors, and vendors. The Management, Research, and Analysis Section serves as OIG's primary liaison with Illinois Medicaid's contracted MCOs as well as the Medicaid Fraud Control Unit. 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 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 FY 2022

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
- Nurse midwife services
- Nursing facility services (age 21 and over)
- Outpatient hospital services
- Physician medical and surgical services
- Rural health clinic services
- Tobacco cessation counseling for pregnant women
- Transportation to covered medical services

Optional Services Provided in FY 2022

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:

- Applied Behavior Analyst services
- Case management services
- Certified Registered Nurse Anesthetist
- Chiropractic services
- Clinic services
- Clinical Nurse Specialist
- Dental services, including dentures
- Diagnostic, screening and preventive services
- Durable medical equipment and supplies
- Extended services for pregnant women
- Eyeglasses
- Home & Community-Based Services through federal waivers
- Hospice services
- Inpatient psychiatric services for individuals under 21 years of age
- Intermediate care facility services for individuals age 65 and older in institutions for mental diseases
- Intermediate care facility services for individuals with intellectual disabilities, including state-operated facilities
- Licensed Clinical Social Worker services
- Licensed Psychologist services
- Nursing facility services for individuals under 21 years of age
- Occupational therapy services
- Optometry services
- Physical therapy services
- Podiatric services
- Prescribed drugs
- Prosthetic devices
- Registered Behavior Technician (RBT) services
- Rehabilitative services (Medicaid Rehab Option/School-Based Health)
- Speech, hearing and language disorder services
- TB related services
- Transplant services

TABLE II

THE DEPARTMENT MEDICAL ASSISTANCE PROGRAM Expenditures Against Appropriations - FY 2020 - 2022 *Dollars in Thousands*						
	FY 2020 Expenditures	**Percent**	**FY 2021 Expenditures**	**Percent**	**FY 2022 Expenditures**	**Percent**
Total[1,2]	**$17,403,052.8**	**100.0%**	**$19,596,759.7**	**100.0%**	**$22,150,629.4**	**100.0%**
Hospitals	**1,167,770.1**	**6.7%**	**1,076,175.0**	**5.5%**	**1,020,346.1**	**4.6%**
Long Term Care[3]	**761,751.4**	**4.4%**	**472,896.7**	**2.4%**	**409,509.7**	**1.8%**
Practitioners	**256,411.6**	**1.5%**	**233,186.3**	**1.2%**	**228,287.3**	**1.0%**
Physicians	207,247.0	1.2%	196,555.9	1.0%	186,733.3	0.8%
Dentists	42,256.3	0.2%	31,122.7	0.2%	36,706.8	0.2%
Optometrists	5,597.2	0.0%	4,091.9	0.0%	3,548.8	0.0%
Podiatrists	1,300.7	0.0%	1,405.1	0.0%	1,286.6	0.0%
Chiropractors	10.4	0.0%	10.4	0.0%	11.8	0.0%
Drug	**942,045.0**	**5.4%**	**800,495.0**	**4.1%**	**911,038.7**	**4.1%**
Other Medical	**1,313,075.2**	**7.5%**	**1,492,975.2**	**7.6%**	**2,397,729.0**	**10.8%**
Laboratories	16,661.4	0.1%	45,965.1	0.2%	79,301.6	0.4%
Transportation	57,503.9	0.3%	151,464.5	0.8%	562,832.9	2.5%
SMIB/HIB Expansion[4]	598,333.0	3.4%	625,730.5	3.2%	753,836.6	3.4%
Home Health Care/ DSCC	176,065.0	1.0%	199,094.4	1.0%	192,356.8	0.9%
Appliances	29,111.0	0.2%	25,567.0	0.1%	28,475.1	0.1%
Other Related[5]	206,118.6	1.2%	230,884.0	1.2%	569,596.1	2.6%
Community Health Centers	55,439.9	0.3%	40,585.3	0.2%	62,391.4	0.3%
Medically Complex Development (MCDD)[6]	113,590.7	0.7%	123,440.2	0.6%	116,052.5	0.5%
Hospice Care	60,251.7	0.3%	50,514.2	0.3%	32,886.0	0.1%
Managed Care	**12,961,999.5**	**74.5%**	**15,521,031.5**	**79.2%**	**17,183,718.6**	**77.6%**
Children's Health Rebate	**0.0**	**0.0%**	**0.0**	**0.0$**	**0.0**	**0.0%**

[1] Not included in total spending are expenditures from the (Cook) County Provider Trust, University of Illinois Hospital Services, Non-entitlements, Hospital Provider Fund (relating to the assessment), Trauma Center, Special Education Medicaid Matching, Money Follows the Person Budget Transfer, Electronic Health Record Incentive, Medicaid Buy-In, Medical Special Purposes Trust, Medical Interagency Program, and Juvenile Rehabilitation Services Funds.

[2] Provider line expenditures excludes FY 2017 administrative spending from the Healthcare Provider Relief Fund.

[3] Includes funds from the Provider Assessment Program, IMDs and SLFs.

[4] Includes amounts paid via offsets to federal financial participation draws.

[5] "Other Related" refers to medical services, equipment and supplies not paid through any other program, such as enteral feeding tubes.

[6] Program transitioned from DHS to HFS on April 2019.

Table Prepared By: Division of Finance Data Source: Division of Finance, Comptroller Spending Report FY 2022.

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.