ILLINOIS DEPARTMENT OF
Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, HFS Director

FY 2021

ANNUAL REPORT

MEDICAL ASSISTANCE PROGRAM

April 1, 2022

Department of Healthcare & Family Services
Health*Choice*Illinois
Your Health. Your Choice.

A LETTER FROM THE DIRECTOR

Theresa Eagleson, Director

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

On behalf of the Department of Healthcare and Family Services (HFS), I am pleased to present the Fiscal Year 2021 Annual Report of the Department's medical assistance programs – often also known as Medicaid, CHIP, All Kids, and other special eligibility programs. Every day, we advance the commitment of our mission, providing access to high-quality healthcare for more than three million Illinoisans. We have also made equity the foundation of our work as we empower our customers to maximize their health and well-being.

Throughout FY2021, helping our customers and providers respond to COVID-19 remained central to the Department's medical assistance programs. At the same time, the Department drove forward a wide range of initiatives to offer expanded and better care and to improve customer and provider experiences.

Among these achievements:

Nine innovative organizations were selected to receive Healthcare Transformation Collaboratives funding, with the goal of bringing whole-person care to their communities – strongly focused on equity. To provide safer and more equitable senior care, the Department issued a series of recommendations for increasing nursing home funding, while at the same time ensuring staffing needed by residents and enhancing quality. New coverage was initiated to provide first-in-the-nation postpartum care for 12 months and to ensure healthcare access to undocumented older adults. The Department also enhanced services and rates to ensure choice for Illinoisans exercising reproductive rights as well as the rights of LGBTQ individuals.

This report provides details on these and many other specific initiatives, as well as participant numbers and provider reimbursements for Fiscal Year 2021 (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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CHAPTER 1

OVERVIEW

ABOUT HFS

The Department of Healthcare and Family Services (Department or HFS) administers the medical assistance programs most commonly known as Medicaid, CHIP, and All Kids. These programs are jointly financed by state and federal government funds and provide critical health care coverage to Illinois' most vulnerable populations.

MISSION

We work together to help Illinoisans access high quality health care and fulfill child support obligations to advance their physical, mental, and financial well-being.

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 2019	FY 2020	FY 2021
Children	1,338,234	1,406,402	1,465,904
Adults with Disabilities	254,741	253,204	252,650
ACA Newly Eligible Adults	570,551	641,711	774,007
Other Adults	498,238	523,468	640,548
Seniors	217,220	230,270	260,929
Total Comprehensive	2,923,984	3,055,055	3,394,038
Partial Benefit Enrollees	43,213	46,984	46,467
Total Enrollees	**2,967,197**	**3,102,039**	**3,440,505**

HEALTH CARE PROGRAMS

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

All Kids Assist

Eligibility - Children up to age 19 with family income at or below 147% of the Federal Poverty Limit (FPL) ($3,246 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 $3,247 and $3,467 per month for a family of four (4)).   **Presumptive Eligibility** - Yes   **Benefit** - Comprehensive   **Cost Sharing** - Yes

All Kids Premium Level 1

Eligibility - Children up to age 19 with family income above 157% and at or below 209% FPL (between $3,468 and $4,615 per month for a family of four (4)).   **Presumptive Eligibility** - Yes   **Benefit** - Comprehensive   **Cost Sharing** - Yes

All Kids Premium Level 2

Eligibility - Children up to age 19 with family income above 209% and at or below 318% FPL (between $4,616 and $7,023 per month for a family of four (4)).   **Presumptive Eligibility** - No   **Benefit** - Comprehensive   **Cost Sharing** - Yes

Department of Children and Family Services (DCFS)

Eligibility - Children in DCFS custody and those placed in subsidized guardianship and adoption assistance arrangements. No income or resource limitations.   **Presumptive Eligibility** - No   **Benefit** - Comprehensive   **Cost Sharing** - No

Former Foster Care

Eligibility - Former DCFS youth in care age 19-25 who were enrolled in Medicaid when aged out of foster care. No income or resource limitations.   **Presumptive Eligibility** - No   **Benefit** - Comprehensive   **Cost Sharing** - Yes

Moms and Babies

Eligibility - Pregnant women and their babies up to age one (1) with a family income at or below 213% FPL (at or below $4,704 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 ($3,048 per month for a family of four (4)) for adults.   **Presumptive Eligibility** - No   **Benefit** - Comprehensive   **Cost Sharing** - Yes

ACA Adults

Eligibility - Adults age 19-64 without minor children in the home who do not receive Medicare and have income up to 138% FPL (monthly income up to $1,481 for an individual or $2,003 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 ($1,073 for a single person and $1,452 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, aged 16 – 64, with disabilities and earnings up to 350% FPL ($3,757 per month for an individual, $5,081 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 age 19-64, who were not dishonorably discharged from the military, served 180 days in the military after initial training, are income eligible, and are not eligible for health care from the U.S. Department of Veterans Affairs or medical assistance under the Public Aid Code.
Presumptive Eligibility - No   **Benefit** - Comprehensive   **Cost Sharing** - Yes

Emergency Medical for Non-Citizens

Eligibility - Persons who are not U.S. citizens or do not have a legal 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 $7,970 for a single person and $11,960 for a couple.   **Presumptive Eligibility** - No   **Benefit** - Coverage of Medicare cost sharing expenses   **Cost Sharing** - Not Applicable

State Immigrant Senior Program

Eligibility - Illinois residents age 65 and over whose immigration status does not meet the requirements for coverage under another eligibility group. Same income and resource standards as AABD medical.
Presumptive Eligibility - No   **Benefit** - Partial   **Cost Sharing** - Yes

The following are the health care services administered by HFS for customer who are ineligible for Medicaid that 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 (Illinois Health Benefits & All Kids Hotline)	1-866-468-7543
Client Eligibility- AVRS for Providers Only	1-800-842-1461 1-800-642-7588
TTY (for hearing impaired) Handled by Next Talk	1-877-204-1012
Client Eligibility – AVRS for Clients	1-855-828-4995
Kids Now (Federal Toll Free Number connecting directly to the Medicaid or CHIP Staff in the state from which the call is made. In Illinois, it connects to the Illinois Health Benefits and the All Kids Hotline.)	1-877-543-7669

PROGRAM COSTS

During FY 2021, HFS spent approximately $26.3 billion (all funds), of which $19.6 billion was from the General Revenue Fund (GRF) or GRF-related funds on enrollee health benefits and related services. (See Table II in appendix for HFS FY 2021 spending by appropriation line).

Medical Programs Spending
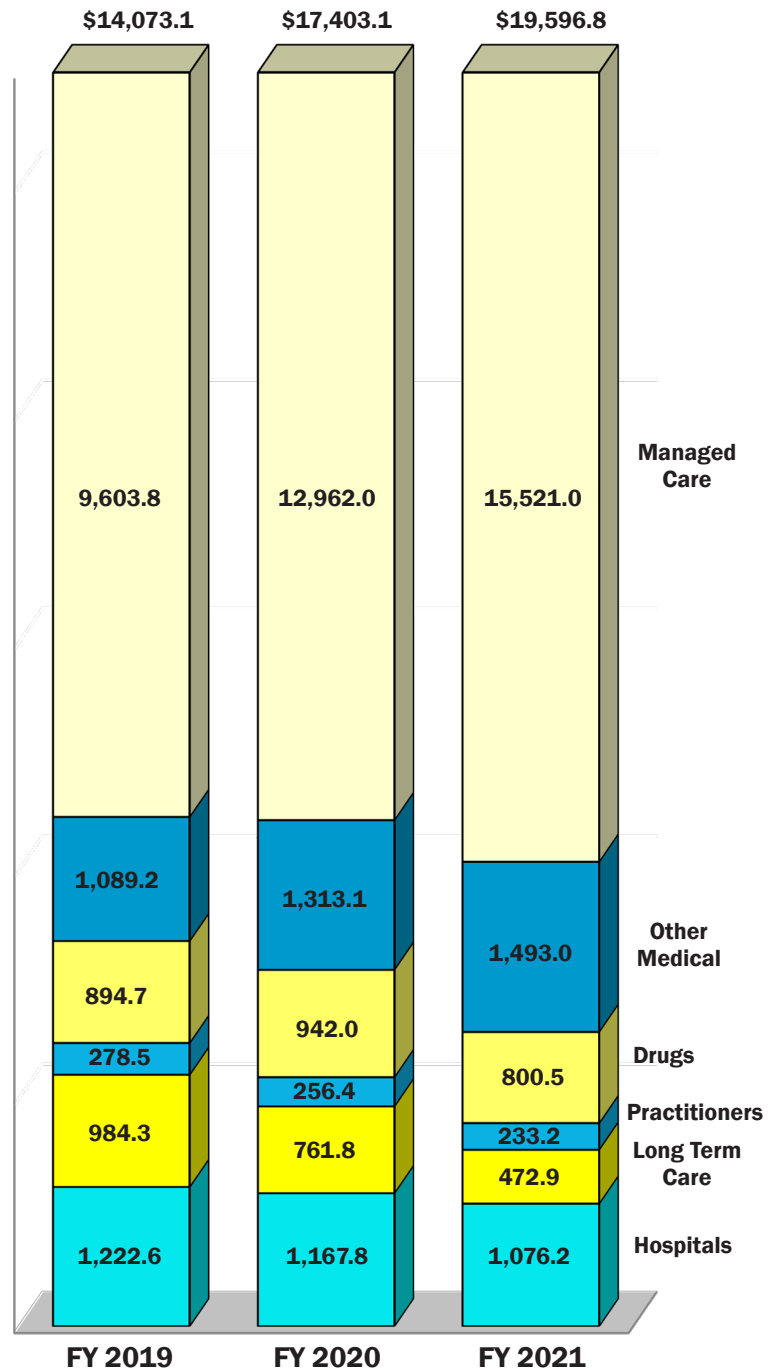*FY 2019 - 2021   Dollars in Millions*

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

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 managed care rates reflecting the imposition of the assessment. The Medically Complex Developmental Disorder (MCDD program transitioned to HFS from DHS.

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

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

Numbers may not appear to add due to rounding.

	$14,073.1	$17,403.1	$19,596.8	
Managed Care	9,603.8	12,962.0	15,521.0	
Other Medical	1,089.2	1,313.1	1,493.0	
Drugs	894.7	942.0	800.5	
Practitioners	278.5	256.4	233.2	
Long Term Care	984.3	761.8	472.9	
Hospitals	1,222.6	1,167.8	1,076.2	
	FY 2019	**FY 2020**	**FY 2021**	

Graph Prepared By: Division of Finance
Data Source: Division of Finance, Comptroller Spending Report FY 2019-2021.

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.

CHAPTER 2

TRANSFORMATION

TRANSFORMING MEDICAL ASSISTANCE

While responding to the COVID-19 Public Health Emergency remained central to the Department's operations, HFS continued improving services for our customers and responding to emerging needs and opportunities in communities throughout Illinois.

Significant Department Achievements - Among major accomplished goals:

- After eliminating significant eligibility backlogs in partnership with DHS, continued processing at an efficient rate
- First in the nation to provide post-partum coverage for 12 months
- First in the nation to cover undocumented older adults
- Implemented MCO reforms to ensure broader access to care and accountability
- Major revamp of Hospital Assessment to meet federal requirements
- Emergency telehealth guidelines shifted to permanent status
- New coverage for diabetes prevention and management
- Gender reassignment surgery coverage for transgender customers
- Development of new Quality Strategy to gauge and guide successful outcomes

Advancing Healthcare Equity

Many of the Department's initiatives focused fundamentally on the central vision of "addressing the social determinants of health" and making equity "the foundation of everything we do." Among these:

- Nursing home rate reform to provide better care in areas disproportionately impacted by COVID-19
- Healthcare Transformation Collaboratives targeted largely to underserved communities of color
- Development of the PACE program (community-based senior care), which will launch in mostly Black and Brown ZIP codes
- Creation of the Pathways to Success program, which will help children with behavioral and mental health needs
- Additional funding for home and community-based services (HCBS)
- Implementation of the Health Care and Human Services Reform Act (the Legislative Black Caucus' healthcare pillar) addressing inequities and obstacles, establishing new programming and increasing oversight and trainings
- New maternal and child health programs vital to promoting equity

Technology Transformation

Developing a state-of-the art technology platform continued in FY 2021. This platform replaces a decades old system that inhibited efficient and effective reporting, analytics, and timely decision making. The new systems are designed to enhance program integrity and increase efficiency while reducing costs. Major system milestones include:

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

CHAPTER 3

CARE COORDINATION

CARE COORDINATION

Overview

On January 1, 2018, the HealthChoice Illinois Managed Care Program expanded to provide statewide, mandatory coverage to most Medicaid customers with comprehensive medical benefits. Managed care offers Medicaid customers enhanced health care coordination and quality services at sustainable costs. While the program is seeing the promise of these goals beginning to be met, the Department continues to work closely with the Managed Care Organizations (MCOs), key stakeholders, including healthcare associations, hospitals, and other providers, to improve efficiencies around billing, payment, administration, and other systems and to increase the overall health of our customers.

As of January 1, 2022, almost 80% of Illinois Medicaid beneficiaries were enrolled in comprehensive, risk-based MCOs. For more enrollment information, visit the Department of Healthcare and Family Services' (DCFS) **Facts & Figures page** and the **Care Coordination page** on its website. These pages provide enrollment by county and also by health plan and managed care program by month, as well as a breakdown of enrollment by population type, percentage of customers who actively selected a health plan vs. being auto assigned to a health plan, and customer language preference. Data is updated monthly.

Additional information on HealthChoice Illinois (HCI), including a copy of the HCI model contract between HFS and the health plans, can be found on the **HFS Care Coordination website**. An additional section of the website with information and links specific to helping customers better understand the Managed Care program can be found **here**.

Current Managed Care Programs

The Department continues to operate three distinct care coordination programs within the broader Illinois Medicaid Managed Care program: HealthChoice Illinois (HCI), YouthCare, and the Medicare Medicaid Alignment Initiative (MMAI).

HealthChoice Illinois (HCI)

In FY 2021, HFS held contracts with a total of five (four statewide, plus one Cook County only) qualified, experienced, and financially sound Managed Care 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.

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 Medicaid fee for service.

The Special Needs Children population began participating in HCI in February 2020 (except Youth in Care), and includes children who are receiving Supplemental Security Income (SSI), children who are enrolled in the Division of Specialized Care for Children (DSCC) CORE program, children with a physical disability category of eligibility, and children formerly under the custody or guardianship of the Department of Children and Family Services (Former Youth in Care).

HealthChoice Illinois - YouthCare

The statewide, specialized HCI health plan, operated by Meridian Health, provides services to DCFS Youth in Care as well as DCFS Former Youth in Care. YouthCare is designed to improve access to care through active coordination and a more robust provider network. With YouthCare, DCFS youth receive additional benefits, such as care coordination for behavioral health needs, including trauma-informed care. YouthCare also offers 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 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 Department of Children and Family Services has legal responsibility, living with foster parents, in group homes, or in residential settings. YouthCare began administering benefits for youth in care on September 1, 2020.

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. YouthCare began administering benefits for former youth in care on February 1, 2020.

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 (dually eligible) by providing coordinated care. In July 2021, MMAI became operational statewide with a total of five (5) MCOs contracted to provide services under MMAI. The Managed Care 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 that 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 fee for service (FFS) population, such as: physician and specialist care, emergency care, laboratory and x-rays, mental health, pharmacy, dental, vision, substance use services, case management, 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 enrollee's health plan (i.e. long term care, HCBS waiver services, behavioral health services, non-emergency transportation, and care coordination). All other Medicaid covered services for the MLTSS enrollees are covered through the HFS fee for service system.

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

Response to COVID-19

Building on its investments to fight against the COVID-19 public health emergency, HFS modified the health plans' 2020 pay-for-performance (P4P) framework so that health plans could reinvest in strategies that mitigate the impact of the virus. HFS determined that its quality metrics would be affected in unprece-dented ways because of changes in utilization associated with the pandemic. Rather than relying on performance metrics disrupted by the pandemic, HFS asked the health plans to submit proposals for how they would invest the funding into Illinois communities. Approximately $100 million of the P4P quality payments was reinvested, as additional capital, into community organizations and providers across Illinois. Investments were directed with a lens toward equity and the greatest impact for organizations and providers that were not already receiving other support. Nearly half of the total redirected quality payments were spent in areas disproportionately impacted by COVID-19.

Health plans invested in critical services and initiatives to help Medicaid customers and providers during the pandemic, such as increasing reimbursement rates for behavioral health providers; expanding

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 which were the hardest hit by the pandemic; providing technology assistance; extending housing benefits; and providing food and funding to school-based health centers.

Health plans are actively promoting COVID-19 vaccinations among members through text messaging, email and phone campaigns, social media, education videos and print materials. Health plan staff are assisting members with making vaccination appointments and arranging transportation as well as partnering with provider and community groups to promote and host vaccination events.

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

Supports for Providers

HFS continues to recognize the importance of supporting providers in successfully navigating the managed care programs. The Department, in partnership with the health plans, has established various supports for providers, 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. Key initiatives that have been undertaken to support providers include developing billing/claiming guidelines compiled in a Comprehensive Billing Manual, a Provider Complaint Portal, and regular provider meetings.

Comprehensive Billing Manual for Providers

The HCI health plans, in collaboration with the Illinois Association of Medicaid Health Plans (IAMHP), and with cooperation from the Department, developed a comprehensive billing guide for most Medicaid enrolled provider types. The manual compiles in a single source, all MCO claims policies and procedures for ease of reference. The claims and billing related policies and procedures across all health plans reduces denials of provider claims and improves provider relations. MCOs have different policies and procedures related to billing. With this manual, the MCOs have created a single source of information for all claims regardless of provider type and helps providers who are contracted with the MCOs understand the general MCO billing requirements. The billing manual continues to be updated to include additional provider types and reflect changes to billing policies and procedures as they are implemented. HFS issues a Provider Notice with a summary of changes to notify providers whenever an updated to the IAMHP billing manual is published. The current approved version of the billing manual can be found on the IAMHP **website**.

Provider Resolution (Complaint) Portal

All Providers are required to submit any disputes they are unable to resolve directly with an MCO 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 goal of the portal is to encourage communication between the MCO and Provider and to ensure fair resolution of disputes in an electronic and secure format.

The provider dispute resolution process requires providers to use the MCO 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. The MCOs then have thirty (30) calendar days to issue its written proposal to resolve the disputed complaint ticket. Sanctions are issued to MCOs for untimely portal resolution responses. In 2020, only one sanction was issued to an MCO for an untimely proposal response in the portal. In 2021, no sanctions were issued to the MCOs. HFS reports on the number of complaints received in the Portal by MCO quarterly, including the trends by health plan in the MCO Performance Metric Dashboad Summaries. Reports can be accessed through the HFS **Report Center webpage**.

Admission, Discharge and Transfer (ADT) System

In 2021, the Department implemented a statewide data exchange platform that holds customer information and shares it with connected Illinois Medical Assistance Program providers and MCOs in a timely and secure manner. The platform will send real-time exchange of ADT notifications from the admitting or discharging facility to a patient's care coordinator or primary care provider resulting in improved care coordination, higher quality care, and more successful outcomes. MCOs, hospitals, and other providers will subscribe to the ADT notification service to receive real-time data for their Medicaid members/patients. During the first phase of the platform, the Department worked to on-board the MCOs and as many providers as possible by September 30, 2021. The first phase of the platform allows for admission, discharge, and transfer alerts to be shared with providers whose patients visit a hospital or emergency department. Future phases will enable sharing of other types of data to support the goals of HFS' Comprehensive Medical Programs Quality Strategy.

MCO-Provider Association Meetings

To further promote relationship building and the successful resolution of disputes between providers and MCOs, HFS continues to facilitate regular joint meetings between IAMHP, the MCOs, and representatives of various Medicaid provider groups participating in the HCI program. The meetings offer providers an opportunity for providers and MCOs to work together to identify and address claiming and billing issues impacting provider payments, and to track issues until they are resolved. Meetings continue to occur on a monthly basis and are shifting from billing/claiming issues to additional operational topics and opportunities for MCO/provider partnerships in 2022.

Advance Communication Engine (ACE)

The State implemented an Advance Communication Engine to capture 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 managed care customers. An ACE dashboard will be created with drill down features to analyze the data by MCO and by Provider name, Provider type, Safety-Net Hospitals and Behavioral Health facilities. In addition, the ACE will identify and report on the top ten reject/denial reasons and top ten reject/denial providers.

MCO Consumer Report Cards

HFS continues to utilize and publish a consumer quality comparison tool, called the HealthChoice Illinois 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 Illinois' 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 EQRO annually. Samples of the HealthChoice Illinois Consumer Report Card is found **here**.

MCO Reimbursement

HealthChoice Illinois 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 consulting actuaries. Adjustments are made for health care management, trend, and health plan administration. All capitation rates must be actuarially sound per federal regulations (42 CFR 438.4(a)). Rates may be updated periodically to reflect future time periods, additional service packages, additional populations, or changes that affect the cost of providing covered services that the Department determines to be actuarially significant.

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

Pay for Performance (P4P) Measures: In addition to capitation rates, the HCI contracts have pay for performance (P4P) measures to incentivize spending on care that produces positive quality of life outcomes. P4P measures are ensured by withholding a percentage amount (Withhold) from the MCO's capitation rate. The MCOs can earn back the Withhold by meeting or exceeding the goals set by the P4P measures. P4P measures are negotiated between the MCOs and HFS to determine which measures promote the goals of the contracts. 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.

Medical Loss Ratio (MLR): MLR means that MCOs must utilize a defined percentage of its capitation rates for health care services, quality improvement, and administrative costs. Under the HCI reboot, the MLR was 85% (a minimum of 85% must be spent on health care services and quality improvements, and a maximum of 15% may be spent on administrative costs).

MCO Program Information

HealthChoice Illinois	Health Plans	June 2021 Enrollment
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	Aetna Better Health of Illinois	410,547
	Blue Cross Community Health Plans	641,401
	CountyCare Health Plan (Cook County only)	402,593
	MeridianHealth*	900,608
	Molina Healthcare	313,242
	Total Health Plan Enrollment	**2,668,391**

*Enrollment includes Youth in Care and former Youth in Care populations.

MMAI	Health Plans	June 2021 Enrollment
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 as of July 1, 2021. To see which plans operate in each county, please link to the **Map of Managed Care**. **Mandatory Enrollment:** No	Aetna Better Health Inc.	8,919
	Blue Cross and Blue Shield of Illinois	18,834
	Humana Health Plan	9,134
	Meridian Complete Health Plan Inc.	13,000
	Molina Healthcare of Illinois	8,825
	Total Health Plan Enrollment	**58,712**

Program Participation	Health Plans	June 2021 Enrollment
HCI, MMAI	Aetna Better Health Inc.	419,466
HCI, MMAI	Blue Cross and Blue Shield of Illinois	660,235
HCI	CountyCare Health Plan	402,593
MMAI	Humana Health Plan	9,134
HCI, MMAI, YouthCare	Meridian Health Plan Inc.	913,608
HCI, MMAI	Molina Healthcare of Illinois Inc.	322,067
	Total MCO Enrollment	**2,727,103**

Quality Assurance

State Quality Assessment and Performance
Improvement Strategy for Managed Care

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

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. HFS 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 HFS' mission of health equity and to drive progress HFS, developed 5 pillars for improvement as it restructured its Pay for Performance and Pay for Reporting measures. Health plans are required to report out on the measures assigned to each pillar by Race, ethnicity, gender, and preset zip codes. The 5 pillars included:

1. Maternal Child Health
2. Adult Behavioral Health
3. Child Behavioral Health
4. Equity
5. Community Based Services and Supports

Each pillar has both Pay for Performance and Pay for Reporting measures.

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 outcomes 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 External Quality Review Organization (EQRO):

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

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

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

CHAPTER 4

LONG TERM SERVICES

& SUPPORTS

LONG TERM SERVICES & SUPPORTS

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

Institutional

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

- 683 NF
- Averaged 43,753 beneficiaries served in FY 2021

Specialized Mental Health Rehabilitation Facilities (SMHRFs)

- 23 SMHRFs
- Averaged 3,364 beneficiaries served in FY 2021

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

- 196 ICF/IIDs
- Averaged 3,728 beneficiaries served in FY 2021

Medically Complex for the Developmentally Disabled Facilities (MC/DD)

- 10 MC/DDs
- Averaged 830 beneficiaries served in FY 2021

Licensed & Medicaid Certified LTC Beds
Fiscal Year 2021 Actual

Level of Care	Medicaid Certified Beds[1]	Licensed Beds[2]
Skilled Care	71,058	78,905
Specialized Mental Health Rehabilitation Facilities (SMHRFs)	0	4,324
Intermediate Care (ICF)	8,809	9,161
Intermediate Care for Individuals with Intellectual Disabilities	4,165	4,165
Skilled Care for Individuals with Intellectual Disabilities	936	936
Total	**84,968**	**97,491**

[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 2019 - 2021

Long Term Care - Total				
	FY 2019	FY 2020	FY 2021	% Change FY 2019 to FY 2021
Total Charges ($ Millions)	$1,889.59	$1,458.71	$1,414.89	-25.12%
Total HFS Liability[1] ($ Millions)	$1,027.63	$690.69	$522.03	-49.20%
Total Patient Days (Millions)	10.15	5.91	4.56	-55.07%
Weighted Average Rate[2] Per-Diem	$101.24	$116.87	$114.48	13.07%
Average Payment (Charge) Per-Diem[3]	$186.17	$246.82	$310.28	66.67%

[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 Illinois ans. Funds generated by the Program are set forth below:

Fiscal Year	Nursing Facilities	ICF/IIDs
2018	$181.5	$16.9
2019	$200	$17.6
2020	$168.7	$18.3
2021	$162.6	$20.2

In millions

Nursing Facilities

The Department has numerous responsibilities for NFs. It is responsible for developing NF policy in accordance with State and Federal regulations, enrolling providers, and ensuring that sanctions set by IDPH are implemented. The Department works on a variety of billing issues such as ensuring that correct payments to providers are made by a system of ongoing pre-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 fee for service program, NFs are paid a per diem rate. There are three separate components to the per diem rate – nursing, capital, and support.

Capital & Support Component	Nursing Component
Based on cost reports the NFs submit to the Department.	Based on geographic location of the NF and the NF's case mix (average resident needs and service provided to each resident within the NF).

Effective January 1, 2014, the Department implemented the Federal RUG-IV 48 grouper methodology as directed by **Public Act 098-0104** to determine the NF case mix for the nursing component of the NF reimbursement. The individual needs of the patients and the actual services provided by the NFs are obtained from an MDS assessment performed quarterly by NFs for each Medicaid eligible resident.

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

- New NFs – New NFs do not have an established rate. For the nursing and support components of the rate, these NFs are given the median rate for their geographic area. The NF's capital costs are used to determine the capital portion of the rate. Four new NF had a rate established in FY 2021.
- 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 2021 twelve (12) NFs and three (3) ICF/IIDs voluntarily closed. Seven (7) NFs closed due to financial hardship and Two (2) NF's closed due to staffing issues. Three (3) ICF/IID converted to a Community Integrated Living Arrangement (CILA). All residents were relocated to appropriate settings. Four (4) new NFs; no (0) SMHRF and no (0) new ICF/IIDs were enrolled in the medical assistance program during this same period.

Eligibility Processing

Public Act 98-0104 requires HFS and DHS to:

- ***Complete LTC eligibility determinations in a timely manner.***
  DHS has continued their focus on LTC case processing and continual training. The 4th LTC hub in Anna was created on 01/16/2021. They are in the process of hiring new staff and training existing staff until they reach their desired headcount. The LTC processing unit continues to assist with over-flow work and 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 HFS continue to utilize a database of pending LTC applications and admissions to ensure applications and admissions are tracked based on age and status. HFS 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 less than 20 by the end of December 2021. Applications pending with the HFS Office of Inspector General for resource review were 160 the end of December 2021. DHS and HFS continue to work 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 State continues to explore both the technical and budgetary feasibility of incorporating more information into the online application system and working with the IES team to identify every

opportunity to add increased usability for LTC applicants. The applicant continues to have the opportunity to upload required verifications with the electronic submission of the Application for Benefit Eligibility (ABE). 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 individual's/resident's case. The State has made several updates to IES which has improved application processing. The State continues to make updates to IES and ABE in order to better serve customers and providers.

- ***Develop and implement a streamlined LTC application process.***
  DHS and HFS representatives meet regularly to identify ways to streamline the application process. Training sessions on using the ABE application system and the provider portal were videotaped for use as webinars on the HFS website. The State continues to incorporate every electronic source currently available into the IES system to minimize the amount of information required to be provided by the client to prove eligibility. Including AVS, which is an electronic asset verification system. Some in formation is not available from current electronic sources and must be requested from the applicant.

Home and Community-Based Services (HCBS) Waivers

In an effort to provide alternatives to NF placement, the Department, in collaboration with the Departments on Aging and Human Services and the University of Illinois, also offers care through nine (9) Home and Community-Based Services (HCBS) waiver programs. The nine (9) HCBS waivers served 136,533 people in state fiscal year 2020. The Department, in its role as the single state Medicaid agency, provides administrative coordination, direction, oversight, program, fiscal, and quality monitoring for all nine (9) waivers.

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

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

| Waiver	Operating Agency
Persons with HIV or AIDS	Department of Human Services (DHS) Division of Rehabilitation Services (DRS)
Persons with Brain Injuries	DHS-DRS
Persons with Disabilities	DHS-DRS
Adults with Developmental Disabilities	DHS-Division of Developmental Disabilities (DDD)
Children and Young Adults with Developmental Disabilities - Support	DHS-DDD
Children and Young Adults with Developmental Disabilities-Residential	DHS-DDD

Persons who are Elderly	Department on Aging
Medically Fragile, Technology Dependent Children	University of Illinois Chicago, Division of Specialized Care for Children (DSCC)
Supportive Living Program	HFS

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

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a rule (**42 CFR 441. 301(c)**) related to HCBS waiver settings. This rule requires that any setting that provides HCBS waiver services demonstrate the characteristics of a community-based, rather than an institutional setting. States are required to bring provider settings into compliance with the rule by March 17, 2022. The Department has developed, with the HCBS waiver operating agencies and guidance from CMS, a statewide transition plan to ensure proper roll out, implementation, and long term compliance with this rule. In July 2020, the Department received CMS approval of our initial statewide transition plan and is currently working with operating agencies to ensure full compliance with the Settings Rule and obtain final approval of the state-wide transition plan. Currently, the Department is working with providers and operating agencies to complete site validation to ensure all HCBS settings meet the settings requirements. A copy of the state-wide transition plan can be found at **https://www2.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx**.

Waiver Expenditures & Beneficiaries Served
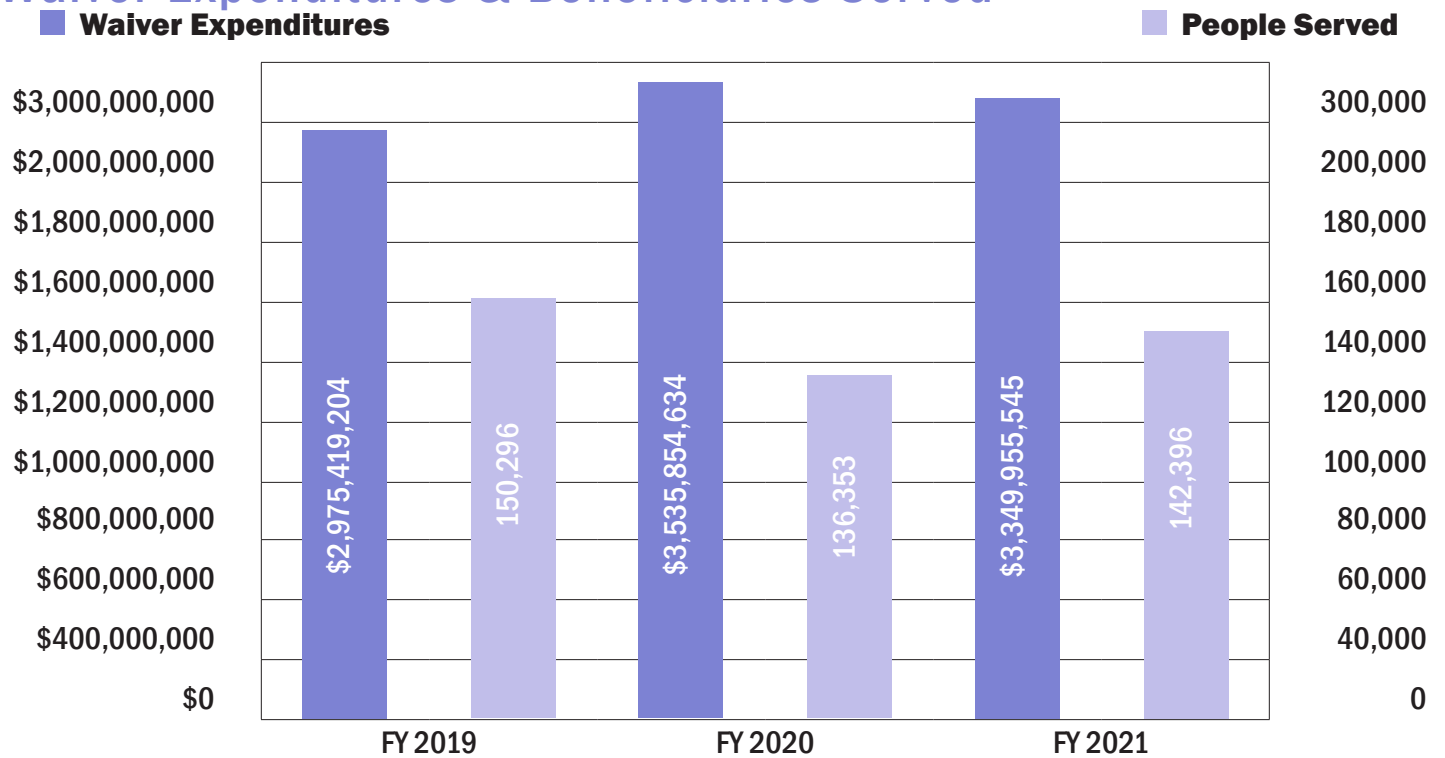
Note: All data was compiled from the Enterprise Data Warehouse (EDW) FY 2021 figures are preliminary and are expected to increase due to waiver expenditure data reported up to 18 months after expenditures are incurred. In 2021, enrollment grew as expected. Overall expenditures decreased by $9.5 million. This is due to a decrease in service utilization across all waivers during the COVID-19 pandemic and customers refusing to allow workers into their homes.

Quality Assurance

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

LTC Rebalancing

Money Follows the Person

Money Follows the Person (MFP) was a federal demonstration program that provided participating states enhanced (an additional 25% to the regular match) federal Medicaid matching funds for their expenditures on HCBS to Medicaid clients transitioning out of institutional settings. States were required to use these enhanced funds to improve access to HCBS and for systemic improvements to their HCBS systems. The MFP program was phased out. MFP stopped accepting referrals on June 30, 2018 and ceased initiating participant transitions on December 31, 2017. This program officially closed as of September 30, 2020.

The Consolidated Appropriations Act of 2021 reauthorized the Money Follows the Person program. The Department is working to reapply for the program.

Although the MFP program ended, the Department remains committed to transitioning Medicaid clients from institutional settings back to the community. HFS works with sister state agencies and Managed Care Organizations (MCOs) to assist in these transitions.

HFS 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.

COMMUNITY

CHAPTER 5

HOSPITAL SERVICES

HOSPITAL PROVIDER REIMBURSEMENT

Hospitals are reimbursed in several ways, including:

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

Please Note: The payment and utilization data presented in this section and the outpatient section that follows includes those individuals covered under fee for service reimbursement as well as a Medicaid Managed Care plan.

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.

250 cost reporting hospitals participated in the Illinois Medicaid program in FY 2021

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 2021 hospital inpatient liability, including payments for both FFS and Encounter claims totaled $2.685 billion, relatively flat from the $2.684 billion spent in FY 2020. This corresponds with a 3% decrease in total inpatient admissions.

QUALITY

As shown in the graph on the following page, 65% of the $2.685 billion in state FY 2021 hospital inpatient payments were made pursuant to the APR-DRG based system that was implemented July 1, 2014. This resulted in an increase in APR-DRG claims-based payments, as APR-DRG comprised 60% of hospital inpatient payments in FY 2020.

Approximately 65% of the $2.685 billion in FY 2021 hospital inpatient payments were made pursuant to the APR-DRG based system that was implemented July 1, 2014 (60% in FY 2020).

2021 GRF Hospital Inpatient Spending - $2.7 Billion

Inpatient FY 2021-% of Total Payments

- XOVER
- REHAB
- DRG
- PSYCH
- LTAC
- CHILDRENS
- NON-COST

NON-COST 0.3%
XOVER 0.4%
REHAB 1.9%
CHILDRENS 19.2%
LTAC 3.0%
PSYCH 10.7%
DRG 64.6%

2021 GRF Hospital Oupatient Spending - $1.8 Billion

Outpatient FY 2021 - % of Total Payments

- OP ACUTE
- ESRD
- PSYCH
- REHAB
- NIPS

PSYCH 1.3%
REHAB 0.7%
NIPS 0.2%
ESRD 5.1%
OP ACUTE 92.7%

Ambulatory Care Services

Effective July 1, 2014, the Department replaced the antiquated fee for service, ambulatory procedure listing (APL) outpatient reimbursement system with the Enhanced Ambulatory Procedure Grouping (EAPG) reimbursement system. This was a monumental change in the reimbursement systems, going from a format of paying based on the single highest paid procedure code on the claim, to paying on multiple procedures that are billed on the same claim. The EAPG system works much like a DRG system on the inpatient side, assigning like procedure codes to an EAPG group and assigning relative weights to the EAPG groups based on national averages of resource consumption to provide the services. This new system allows hospitals to be paid for multiple procedures on one claim and also incorporates discounting and consolidation of payments when appropriate.
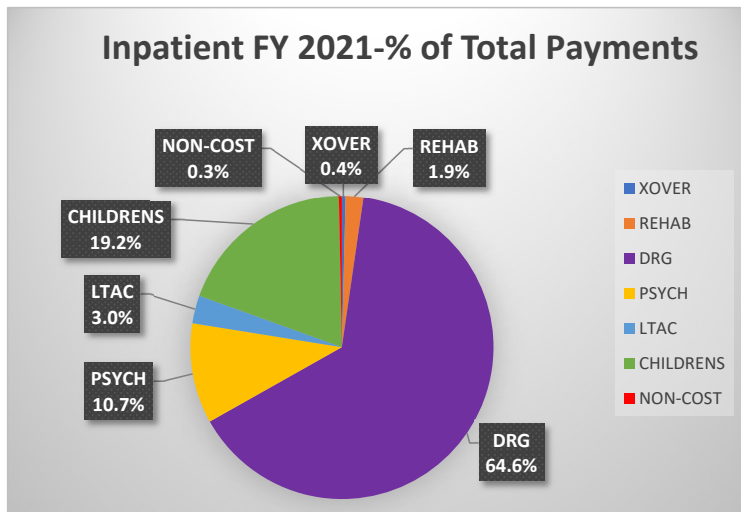
Total 2021 spending on institutional claims paid via the EAPG system was $1.8 billion, up from the $1.4 billion in 2020.

Starting in FY 2021, a billing change occurred that required hospitals to bill Non-institutional Professional Services (NIPS) claims on the institutional claim format. Therefore, the hospital spending under the NIPS category in 2020 has shifted to the Outpatient Acute category in FY 2021.
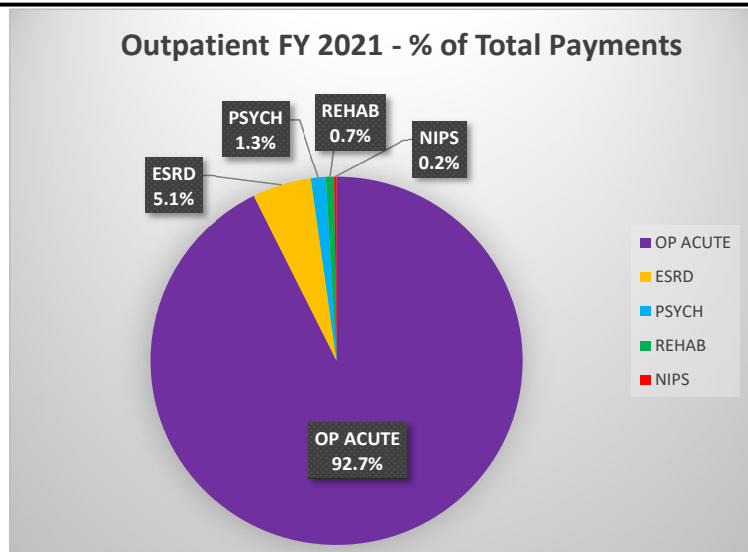
There was a 60% increase in hospital outpatient services, due in large part, to the new NIPS billing requirement.

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.

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 2021, HFS expended $268.5 million the of its federal Disproportionate Share Hospital (DSH) allotment of, which equated to about $469.8 million in total spending including state matching funds.

The following numbers of hospitals qualified for DSH in rate year 2021: 88 private (non-governmental) hospitals, including 26 which received DSH payments because they were within the federal guidelines set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1993; five (5) State-operated psychiatric hospitals qualified for DSH because their low income utilization rate exceeded 25%; and government-owned hospitals (University of Illinois Hospital and Cook County Hospitals and Health Systems). As federally-required, the Department performs an annual OBRA calculation to ensure that spending to each hospital does not exceed the combined costs of services to the Medicaid and uninsured populations.

Non-GRF Funded Hospital Payments

The Hospital Provider Assessment Program was originally implemented in July 1991 and has been changed somewhat since that time. In accordance with Public Acts **95-0859**, **97-0688**, and **98-0104**, HFS is authorized to make hospital access improvement payments to qualifying hospitals. Instead of the State's portion of the payments being funded through GRF, these payments utilize funding garnered through both an inpatient and outpatient assessment on Illinois hospitals. In total, nearly $3.3 billion in payments were made to the hospitals in FY 2021 through both FFS payments and payments made through the Health Choice Illinois Managed Care Organizations.

Total FY 2021 Hospital NON-GRF Payments vs Claims

Payments 42%
Claims 58%
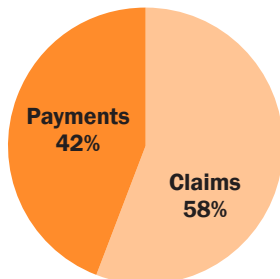
FY 2021 Hospital Payments Inpatient vs Outpatient

Outpatient 40%
Inpatient 60%
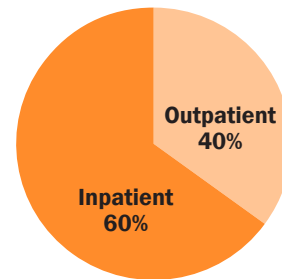
Adjustments to Hospital Assessments

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 July 2020 through December 2020, the amount of actual payments over the modeled amount was $49,477,867. Therefore, the tax adjustment was an increase of $19,063,822. See details below:

Tax Increase Calculations for 01/01/2021

Actual Payments 07/01/2020 – 12/30/2020	$1,359,482,930
Less Modeled Payments	$1,310,005,063
Payment in Excess	$49,477,867
	x .3853
Tax Increase	$19,063,822

In July 2021, the tax adjustment applied during the first half of the year was carried forward to the second half due to the proximity of the funding needed to account for the State's liability for both periods. Aggregate payment amounts for the period of July 1, 2021 through December 31, 2021 totaled $266 million more than modeled. To fund these payments, the tax adjustment implemented January 2022 is detailed below:

Tax Increase Calculations for 01/01/2022

Actual Payments 07/01/2021 – 12/30/2021	$1,576,211,092
Less Modeled Payments	$1,310,005,063
Payment in Excess	$266,206,029
	x .3853
Tax Increase	$102,569,183

Utilization Review & Quality Assurance

State Medicaid agencies are required to provide utilization review and quality assurance review in the inpatient hospital setting for services provided to FFS participants. The Department contracts with a federally designated quality improvement organization-like entity to provide these services. In FY 2021, non-certification of medically unnecessary services resulted in direct cost savings of $3.6 million for HFS.

CHAPTER 6

PHARMACY SERVICES

PHARMACY SERVICES

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

The Department controls access to certain reimbursable drugs via a prior authorization process, and regularly evaluates which drugs should be subject to prior approval based upon the relative safety, efficacy, and costs for covered medications. The 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 requires Managed Care Organizations (MCOs) to cover only drugs made by manufacturers who participate in the federal Medicaid drug rebate program.

Preferred Drug List/Supplemental Rebate Program

FFS
The Department continues to develop and maintain a Preferred Drug List (PDL) at **https://www.illinois. gov/hfs/MedicalProviders/Pharmacy/preferred/Pages/default.aspx**. Development of the PDL is based upon clinical efficacy, safety, and cost effectiveness. As part of the PDL development process, the University of Illinois 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.

Managed Care
The Department requires Managed Care Organizations (MCOs) to cover only drugs made by manufacturers who participate in the federal Medicaid drug rebate program. Through the PDL process, the Department negotiates and contracts for supplemental drug rebates directly with drug manufacturers. These supplemental rebates are above and beyond the rebates provided by the manufacturers under the federal rebate program. In FY 2021, the Department collected approximately $118.3 million in State supplemental rebates from drug manufacturers. In addition to supplemental drug rebates, the Department collected $38 million in rebates on blood glucose testing equipment and supplies. These rebates are collected on both FFS and MCO claims.

Reimbursement Methodology

FFS

During FY 2021, the reimbursement rate for single-source medications (brand name) was the lesser of Wholesale Acquisition Cost (WAC) minus 4.4%, National Average Drug Acquisition Cost (NADAC) or State Maximum Allowable Cost (SMAC), plus a professional dispensing fee. Multi-source medications (generics) were reimbursed at the lesser of WAC minus 17.5%, NADAC, SMAC, or Federal Upper Limit (FUL) plus a professional dispensing fee. The professional dispensing fee for Illinois-based Critical Access Pharmacies is $15.55 and for all other pharmacies, the professional dispensing fee $8.85. The Department's maximum price for each drug continues to be the lesser of the calculated allowable, or the pharmacy's usual and customary charge. Generic prescriptions comprised 89% of drug utilization but represented only 27% of the Department's drug spend.

Under the Pharmacy Billing Management System (PBMS) contract the vendor develops and maintains a comprehensive listing of SMAC reimbursement rates. The Department provides public notice of proposed revisions and additions to monthly SMAC rates at least 14 days prior to effective dates. This policy ensures that pharmacy providers may review and, if necessary, appeal the adequacy of SMAC rates before final rates are implemented. Proposed and final SMAC rates can be found at **www.ilsmac.com**.

Narcotics Management Program

FFS

The Department has constructed a multi-pronged approach to identify and manage members who are at risk for abuse or misuse of narcotics, while, at the same time, allowing adequate medication supply to members who have a clinical need for narcotic pain control.

Limited Preferred Narcotics – In consultation with 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.

Pain Management Program – The Department's pain management narcotic review program identifies members who are receiving inappropriate narcotic pain medications for chronic pain. This program is designed to assess a patient's current pain management plan and ensure that it is in line with national guidelines.

Quantity Limits/Duplicate Edits – The Department has implemented more restrictive quantity limits on narcotic medications. In 2020, patients who had not recently filled a narcotic prescription were limited to a 7-day supply on a new prescription and patients taking narcotic pain medications for chronic pain are being monitored using morphine milliequivalent maximums. If a prescription exceeds these limits, a prior approval is required. The Department also reviews the members' drug profile for duplicate therapy and discusses their findings with the members' prescribing physician to resolve those occurrences.

Narcotic Edit – The Department's Narcotic Edit controls access to any controlled pain medication for members with a clinical profile that indicates the member's utilization needs should be managed closely. All prior authorization requests for members with such a clinical profile result in a comprehensive review of the member's Medicaid prescription history, as well those prescriptions that are reported through the Illinois Prescription Monitoring Program.

Managed Care

The MCOs must have an enrollee restriction program in place, in which, at a minimum, the MCO must restrict an enrollee for a reasonable period to a designated PCP or provider of pharmacy services when:

(1) the Department indicates the enrollee was included in the Department's Recipient Restriction Pro- gram pursuant to 89 Ill. Admin. Code 120.80 prior to enrollment with contractor; or (2) the MCO deter- mines that the enrollee is over-utilizing covered services. The MCOs criteria for such determination, and the conditions of the restriction, must meet the standards of 42 CFR §431.54(e).

In addition, the MCO must have a drug utilization review (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. The MCO is required to report prospective and retrospective DUR activities to the Department annually and to complete the Federal CMS MCO DUR annual report.

Specialty Drug Use

FFS

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

Managed Care

The Department reviews the MCO's utilization controls via various quality assurance reports and the drug utilization review program. Each MCO is required to report prospective and retrospective DUR activities to the Department annually, and to complete the Federal CMS MCO DUR annual report.

Four Prescription Policy

FFS

The Four Prescription Policy requires that participants obtain prior approval for prescriptions after they have filled four (4) prescriptions in the preceding 30 days. Several classes of medications are exempt from the Four Prescription Policy, such as HIV (Human Immunodeficiency Virus) medications, oncology medica-tions, antipsychotic medications, and anti-rejection medications. The purpose of the Four Prescription

Policy is to have providers review their patients' entire medication regimen and, where possible and clinically appropriate, reduce duplication, unnecessary medications, and polypharmacy. Pharmacist reviews under the Four Prescription Policy identify opportunities to improve efficacious drug therapy. Since inception of the policy, new utilization control edits have been implemented to address duplicate therapy, drug interactions, inappropriate use, quantity, and duration of therapy.

Additional information on the Four Prescription Policy is available on the Department's website at **https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/FourPrescriptionPolicy.aspx**.

Hemophilia Care Management Program

FFS

Through the Department's Hemophilia Care Management Program, quality and utilization control initiatives for patients with hemophilia who are receiving blood factor continue to prove effective. As a part of this program, pharmacies must sign a Standards of Care Agreement (SOCA) in order to dispense blood factor to Medicaid participants. In addition, the Department continues to require prior approval for blood factor products to ensure appropriate utilization. Further information can be found on the Department's website at **https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/Pages/Hemo.aspx**.

CHAPTER 7

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.

Illinois also furthered 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. Due to delays in implementation related to the COVID-19 public health emergency, the anticipated implementation date for these services was moved to FY 2022.

The Department launched a standardized Integrated Assessment and Treatment Plan (IATP), the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS). The IM+CANS will assist in improving behavioral health outcomes for members by creating standardization, continuity and consistency in identifying treatment needs as well as member's strengths that can be utilized throughout service delivery. In FY 2021, approximately 3,000 providers received training on the IM+CANS, with a total number of certified users exceeding 6,500.

The Department also moved forward with implementation of an IM+CANS Provider Portal that will allow all providers to upload data from the IM+CANS into a central database. The data collected will allow the Department to tailor services to meet individuals' specific needs. The IM+CANS Provider Portal launched to all providers January 1, 2021. As of June, 2021, 115,000 distinct IM+CANS have been entered into the Provider Portal.

MCOs have been key partners in this transformation. The MCO contracts have quality assurance requirements for the provision of mental health services for adults and children, and contractual requirements related to the mental health delivery system, such as qualifications for mental health professionals, and detailed children's mental health service requirements.

Mobile Crisis Response Services

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, HFS, in collaboration with the

Departments of Children and Family Services (DCFS) and Human Services (DHS), developed the Screening, Assessment and Support Services (SASS) program.

Since July 1, 2004, the SASS program has operated as a single, state-wide system serving children and youth who are experiencing a mental health crisis and whose care requires public funding from HFS, DCFS, or DHS. SASS operates 24 hours a day, 7 days a week for children and youth in the fee for service delivery system. SASS features a centralized point of intake known as the Crisis and

In FY 2021, there were 8,079 unique children/youth who experienced one (1) or more crisis events in Fee-For-Services.

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 2021, the CARES Line received 101,172 calls, of which 97,712 were due to a crisis.

In FY 2021, the managed care system responded to 18,829 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 managed care 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 HFS contracted MCOs. MCR continues to feature centralized intake via the CARES Line and access to face-to-face crisis intervention services. The Departments actively work with HFS contracted managed care entities to ensure coordination and continuity across the crisis response systems.

The Department worked closely with SASS/MCR providers at the beginning of the COVID-19 public health emergency to issue guidance and revise face-to-face service expectations to address the safety of customers and staff. The Department broadened the acceptable use of telehealth for both initial Crisis Intervention and on-site screenings and met weekly with SASS/MCR providers to assist them with adjusting their service provision.

The Department worked with SASS/MCR providers to develop continuity of service plans to ensure that if one provider was unable to respond to crises due to COVID infections among their staff, that there was adequate coverage from an adjacent provider. This process maintained statewide coverage for SASS/MCR throughout the COVID-19 public health emergency.

The Department also developed a COVID-19 symptom checklist and enhanced screening procedures for the CARES line to ensure that SASS/MCR staff were notified of any COVID -19 symptoms that customers may be experiencing. This process ensured that SASS/MCR staff could make appropriate adjustments to their interventions to ensure the safety of customers and staff.

Psychiatric Consultation Phone Line — Illinois DocAssist

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

Family Support Program

Public Act 99-0479 20 ILCS 1705/7.1) required the transition of what was historically known as the Individual Care Grant (ICG) program from the Illinois Department of Human Services – Division of Mental Health (DHS-DMH) to the Department. In FY 2018, HFS revamped the program to better reflect the Department's behavioral health policies through the promulgation of Title 89 Illinois Administrative Code, Part 139 (Rule 139), transitioning what had been the ICG program to the Family Support Program (FSP). Rule 139 redefined eligibility criteria for entering the program, making services more readily available to a wider array of Illinois youth. Rule 139 also introduced utilization management components to ensure those enrolled in FSP are receiving the clinically appropriate level of care. In FY 2021, 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 FSP saw an 11% increase in program enrollment over FY 2020, with 651 youth served in FY 2021.

The Department worked closely with FSP providers at the beginning of the COVID-19 public health emergency to allow extended home-visits for FSP youth to allow the residential providers to continue providing intensive interventions via telehealth while the youth were at home with their families. The Department also lifted the continued eligibility determinations for FSP to ensure that care would not be disrupted during the COVID -19 public health emergency.

Specialized Family Support Program (SFSP)

The Specialized Family Support Program (SFSP) was implemented pursuant to the Custody Relinquishment Prevention Act **20 ILCS 540/**, effective January 1, 2015. It is a collaborative effort between HFS and the Departments of Children and Family Services (DCFS), Human Services (DHS) Juvenile Justice (DJJ), Public Health (DPH) and the Illinois State Board of Education (ISBE). SFSP is designed to identify youth at risk of custody relinquishment and their behavioral health needs and link them and their families to appropriate clinical services to support family reunification.

SFSP is an expansion of the Illinois behavioral health crisis response system for youth utilizing existing resources found in the Screening, Assessment and Support Services (SASS), Comprehensive Community-Based Youth Services (CCBYS) and Intensive Placement Stabilization (IPS) programs.

Through leveraging these existing state resources, altering key program policies to accommodate the specialized needs of this population, and providing access to community stabilization services, SFSP is now actively assessing and linking youth at risk of custody relinquishment and their families to services through the most appropriate State agency. SFSP has been implemented consistent with the Department's efforts related to the behavioral health transformation, including the implementation of the managed care delivery system. In FY 2021, 14 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.

Certified Community Behavioral Health Clinics (CCBHC)

With the passage of PA 102–0043 The Department of Healthcare and Family Services shall 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.

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 the Center for Medicare and Medicaid Services (CMS) for the Illinois SUPPORT Act: Section 1003 Demonstration Project to Increase Substance Use Provider Capacity Initiative.

The Illinois SUPPORT 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 beneficiaries; 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 on who is certified to prescribe MAT and who is actively prescribing MAT.

The COVID-19 public health emergency had a significant impact on the initial implementation timeline; the 18-month planning phase was extended for an additional six months, moving the end date of the grant to September 29, 2021. CMS has offered the opportunity for cost extension for up to 12 months to allow for the completion of grant deliverables that have been delayed by the public health emergency. Illinois will be submitting a request for a no cost extension.

Illinois is planning to apply to CMS for the opportunity to be one of five state who receive a 36-month post planning demonstration. It is anticipated that the Notice of Funding Opportunity will be released in July 2021 with an anticipated application submission deadline of August 2021. If Illinois is selected for the implementation phase, CMS will allow for enhanced reimbursement of SUD and OUD services, which will increase access to MAT and other critical recovery supports for Medicaid members in Illinois.

1115 Waiver Illinois Behavioral Health Transformation

In May 2018, the Illinois Department of Healthcare and Family Services (HFS) received approval of its 1115 Waiver request. This waiver includes pilots designed to better serve Medicaid beneficiaries 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 HFS, in partnership with the Department of Human Services/Substance Use Prevention and Recovery (DHS/SUPR), implemented four substance use disorder (SUD) specific pilots:

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

These pilots include Opioid Use Disorder (OUD)/SUD services delivered by providers 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 Medication Assisted Treatment (MAT) for those patients who need this regimen of care.

In the first three years of the 1115 SUD demonstration (July 1, 2018 through June 30, 2021) there were an estimated:

- 8000 individuals who received treatment through the SUD residential IMD Pilot.
- 2300 individuals who were enrolled in SUD case management services.
- 107 individuals enrolled in Peer Recovery Support Pilot.
- 61 individuals enrolled in the Clinical Withdrawal Management Pilot.

CHAPTER 8

OTHER COMMUNITY

SERVICES & INITIATIVES

OTHER COMMUNITY SERVICES & INITIATIVES

MATERNAL AND CHILD HEALTH PROMOTION

The Department is committed to improving the health of women and children. HFS serves as an advocate in promoting wellness through a continuum of comprehensive health care programs that address such issues as social emotional development, immunizations, lead screening, and family case management. Improving the health status of mothers and children can be achieved through education, prevention, and partnerships with other programs. The MCO must follow specific contractual guidelines for maternal and child health promotion such as family planning and reproductive health, including ensuring that national recognized standards of care and guidelines for sexual and reproductive health are followed. More information on the programs offered by HFS and HFS requirements for MCOs can be found at: **https://www2.illinois.gov/hfs/MedicalProviders/MaternalandChildHealth/Pages/report.aspx**.

The Department identified Maternal and Child Health as one of the pillars in the Pay for Performance (P4P) and Pay for Reporting (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 HFS and the Illinois Department of Public Health (IDPH) on the status of prenatal and perinatal health care services: **https://www2.illinois.gov/hfs/MedicalProviders/MaternalandChild-Health/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.

LOCAL HEALTH DEPARTMENT PARTNERSHIPS

Through agreements signed individually between 78 local health departments (LHD) and the Department, HFS continues to maximize available federal resources by assessing and processing data on expenditures incurred by the LHDs in excess of State payments in order to determine which covered services rendered to Medicaid participants are eligible for federally matchable administrative expenses. This process brings in additional federal funds. The administrative expenses must be paid from local dollars and those dollars must not be used to match any federal awards. The additional funds are passed to the LHDs to provide re- sources for further expansion of services and increased access for Medicaid participants for such services as maternal and child preventive health and dental care.

DENTAL SERVICES

FFS

The FFS HFS Dental program is administered by DentaQuest of Illinois, LLC (DentaQuest). HFS, through DentaQuest, offers many dental services to children and adults. DentaQuest is responsible for dental claims adjudication and payment, prior approval of services, ongoing reporting to the Department and quality assurance monitoring. In addition, DentaQuest provides services aimed at ensuring participant access to care for medically necessary dental services such as provider recruitment and training, enrollee education and referral coordination, an interactive website, and toll-free telephone systems.

DentaQuest reimburses dental providers in accordance with the Department's fee schedule, with weekly payments received from HFS based on the dollar amount of DentaQuest's adjudicated claims.
Link to Fee Schedule - https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/ Pages/Dental.aspx

Managed Care

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

FY 2021 Dental Payments			
	Number of Individuals	**Dental Services**	**Payments**
Individuals under 21	62,521	319,435	$13.8 million
Individuals 21 and over	55,994	433,487	$13.3 million
Total	**118,440**	**752,922**	**$27 million**

Total unique individuals (118,440) does not equal the sum of the two age groups (0-20 or 21 and over) as some individuals reached age 21 in FY21.

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

Bright Smiles from Birth Program

HFS, in cooperation with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), has developed a Statewide Bright Smiles from Birth Program that uses a web-based training to educate physicians, nurse practitioners, and federally qualified health centers on how to perform oral health screenings, assessments, and fluoride and varnish applications in both the FFS and managed care delivery system.

The program also gives guidance and makes referrals to dentists for necessary follow-up care and establishment of ongoing dental services. The initiative has proven successful in improving access to dental care and studies confirm that fluoride varnish applications are effective at reducing early childhood caries in young children. See **https://illinoisaap.org/oral-health/** for more information.

REIMBURSING SCHOOL-BASED HEALTH SERVICES

Approximately 130,000 children received direct medical services through the school-based program during FY 2020. LEAs were reimbursed over $75.1 million for their costs to provide these services, as well as about $75.1 million for care coordination costs and outreach.

Since 1992, the School-Based Health Services program has actively participated in the Medicaid/ education partnership established by the Medicare Catastrophic Coverage Act (**Public Law 100-360**). This partnership allows Local Education Agencies (LEA) to receive Medicaid reimbursement for a portion of the costs incurred to provide direct medical services to Medicaid enrolled children who have disabilities as defined under the Federal Individuals with Disabilities Education Act (IDEA). For more information visit: **SBHS website**.

CHAPTER 8

PROGRAM INTEGRITY

PROGRAM INTEGRITY

The Office of Inspector General for the Department of Healthcare and Family Services (OIG) reports to the Governor of Illinois and has a statutory mandate "to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct" in the Illinois Medical Assistance Program (Medicaid). (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 programs; 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

Audits: The Bureau of Medicaid Integrity (BMI) conducts program integrity audits on all provider types enrolled in Medicaid. Through these audits, the OIG ensures compliance with state and federal law and department policy. The OIG uses a number of factors in determining the selection of providers for audit, including, but not limited to, data analysis; fraud and abuse trends; identified vulnerabilities of the Medicaid program; external complaints of potential fraud or improper billing; and a provider's category of risk.

Audits consist of desk audits, field audits, self-audits, and self-disclosure audits. BMI's in-house auditors evaluate paid claims to determine compliance with Healthcare and Family Services' guidelines and state regulations. A Medicaid provider may also submit and be subject to a self-disclosure audit as the result of the provider's own investigations and review of their billing practices.

BMI also has oversight responsibility for audits conducted by federally-mandated, external auditors—the Recovery Audit Contractor (RAC) and the Unified Program Integrity Contractor (UPIC). The RAC reviews fee-for-service post-payment claims utilizing the State's regulations that providers are required to follow. The federal Centers for Medicaid and Medicare Services' Center for Public Integrity offers State Medicaid Agencies the use of the UPIC to conduct investigations and audits to reduce fraud, waste, and abuse in the Medicaid Program.

Both the internal and external audits may result in recoupment of overpayments, entry into corporate integrity agreements, termination from the program, or referral to the Medicaid Fraud Control Unit (MFCU) for prosecution.

Peer Reviews of Providers for Quality of Care: The Peer Review Unit (PRU) consists of nursing staff and physicians tasked with conducting utilization and quality of care reviews of healthcare furnished to Medicaid recipients by current or new applicant providers such as physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. Quality of care concerns are risk of harm, medically unnecessary care, and grossly inferior quality of care. Risk of harm is identified when there is a risk to the patient that outweighs the potential benefit of the service. Medically unnecessary care is identified when the care provided to the patient is not needed and/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. PRU cases can originate from hotline complaints, internal referrals, or external agencies such as the Illinois Department of Financial Professional Regulation, State Police, Public Health or Managed Care Organizations.

For utilization and quality of care reviews, PRU staff may recommend case closure with or without concerns or a referral to an OIG physician consultant for potentially serious concerns. If the physician consultant only identifies minor concerns, a letter to the provider outlining quality of care concerns and corrective action may be recommended. For more serious quality of care concerns by the physician consultant, the provider may be referred to the Medical Quality Review Committee (MQRC) to review and discuss such concerns. The MQRC consists of OIG staff and medical consultants of like specialty. The MQRC will make a recommendation to the OIG to close the case; send a letter to the provider identifying the concerns, require corrective action, with a time limit to review compliance; refer the matter internally or externally for further action; or recommend administrative action for termination, entry of a corporate integrity agreement, suspension, or denial of reinstatement or enrollment.

PRU also conducts a quality of care review for any providers that submit, through IMPACT, an enrollment application and were previously terminated, suspended, or withdrew from the Medicaid Program or had an action/discipline noted on their license

Long Term Care Asset Discovery Investigations (LTC-ADI): 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 the resources which 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.

Applications are referred to the OIG from the DHS Family Community Resource Centers (FCRCs) as a result of meeting specific criteria. LTC-ADI analysts review applicants' financial records and related information dating up to five years before their benefits applications. LTC-ADI provides its findings to the FCRCs, which notify the applicants of their eligibility.

Quality Control Measurements: Quality Control reviewers within the Bureau of Medical Integrity work with the federal Centers for Medicare and Medicaid Services (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 as well as 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.

BUREAU OF INVESTIGATION

New Provider Verification: The Bureau of Investigations' (BOI) New Provider Verification unit (NPV) reviews areas of concern, such as past convictions or sanctions, in new providers' enrollment applications. NPV gathers additional information and based on its findings makes a recommendation to OIG leadership as to whether to grant or deny the application of enrollment.

NPV continues to monitor new providers that are designated as high and moderate risk for fraud based on their provider type for one year afterwards. Provider claims are analyzed 180 days after enrollment and again after a year since enrollment. 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 (formerly Welfare Abuse Recovery Program): BOI's Complaint Intake Unit serves as the central fraud intake unit for OIG. Complaint Intake processes fraud and abuse referrals received from Managed Care Organizations, local Department of Human Services (DHS) offices, members of the public, and other stakeholders, alleging potential fraud by Medicaid providers and recipients. 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.

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

Provider Investigations: Historically, BOI only investigated allegations of suspected fraud, waste and abuse by recipients of federal benefits. During this fiscal year, the Bureau began 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

Dynamic Network Analysis: The OIG Bureau of Fraud Science & Technology (BFST) oversees the development and maintenance of the Dynamic Network Analysis (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.

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. For example, the "Transportation During Inpatient" routine identifies a transportation provider's potentially fraudulent services during a recipient in-patient hospital stay. Likewise, the "Time Dependent Billing" routine (TDB) aggregates a provider's time incurred for all billed procedure codes based upon CMS service time guidelines. 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.

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 primary care physician, 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.

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

Opioid Usage Dashboard: Opioid use has become 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. As a result of this analysis, a set of packaged reports, including a provider summary report, recoupment worksheet, and audit schedules, are generated.

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.

Outlier Analysis - Provider Type Upstate/Downstate Analysis: Provider Type Upstate/Downstate Analysis is an investigation of whether providers exceed the norm payment within their peer provider type by geographic location (upstate and downstate). Standard deviations measure the amount of variation in the set of data values. A high standard deviation indicates that the data points are spread over a wider range of values. Providers with a high standard deviation trigger further examination.

Outlier Analysis - Provider Type Cluster Analysis: Outlier Analysis by Provider Type examines providers in relation to their cohort. Cohorts, in this analysis, are defined by geographic location and practice and payment patterns. Information is then clustered by merging neighboring counties after calculating average monthly payment values and the number of services, recipients, physicians, transportation providers, dentists, pharmacy providers, Durable Medical Equipment providers, and other providers in each county. As with the Provider Type Upstate/Downstate Analysis, providers with an extremely high standard deviation trigger further examination.

Outlier Analysis - Procedure Code Analysis: Procedure Code Analysis compares the procedure code payment and service distribution for the targeted provider with statewide averages. Ranking in the Procedure Code Analysis represents the hierarchical order of individual providers within the same provider type. For this analysis, BFST uses the procedure code payment distribution discrepancy between the provider and statewide average for provider ranking and the size of a provider's payment. A higher rank for providers indicates a higher probability of fraud. The payment and number of recipients are grouped by rendered procedure codes for a given provider. Simultaneously, the provider's procedure code billing pattern is compared against their peers', given similar circumstances. This analysis identifies suspicious providers with unusual billing behaviors.

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 the Illinois Department of Public Health, Enterprise Data Warehouse, the Centers for Medicare and Medicaid Services, 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 HFS' Medical programs. OIG's Bureau of Internal Affairs investigates misconduct by HFS and Aging employees, contractors, and vendors. The Management, Research, and Analysis Section serves as OIG's primary liaison with Illinois Medicaid's contracted Managed Care Organizations 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 2021

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

- Certified pediatric and family nurse practitioner services
- EPSDT: Early and Periodic Screening, Diagnostic and Treatment Services for individuals under age 21
- Family planning services and supplies
- Federally qualified health center services
- Freestanding birth center services
- Home health services
- Inpatient hospital services
- Laboratory and X-ray services
- Nurse midwife services
- Nursing facility services (age 21 and over)
- Outpatient hospital services
- Physician services
- Rural health clinic services
- Tobacco cessation counseling for pregnant women
- Transportation to covered medical services

Optional Services Provided in FY 2021

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

- 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
- 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)
- TB related services
- Speech, hearing and language disorder services

TABLE II

HFS MEDICAL ASSISTANCE PROGRAM Expenditures Against Appropriations - FY 2019 - 2021 *Dollars in Thousands*					
	FY 2019 Expenditures	**Percent**	**FY 2020 Expenditures**	**Percent**	**FY 2021 Expenditures**	**Percent**
Total[1,2]	**$14,073,119.0**	**100.0%**	**$17,403,052.8**	**100.0%**	**$19,596,759.7**	**100.0%**
Hospitals	**1,222,586.3**	**8.7%**	**1,167,770.1**	**6.7%**	**1,076,175.0**	**5.5%**
Long Term Care[3]	**984,335.2**	**7.0%**	**761,751.4**	**4.4%**	**472,896.7**	**2.4%**
Practitioners	**278,453.0**	**2.0%**	**256,411.6**	**1.5%**	**233,186.3**	**1.2%**
Physicians	218,624.6	1.6%	207,247.0	1.2%	196,555.9	1.0%
Dentists	50,994.4	0.4%	42,256.3	0.2%	31,122.7	0.2%
Optometrists	7,369.6	0. 1%	5,597.2	0.0%	4,091.9	0.0%
Podiatrists	1,449.1	0.0%	1,300.7	0.0%	1,405.1	0.0%
Chiropractors	15.3	0.0%	10.4	0.0%	10.4	0.0%
Drug	**894,689.1**	**6.4%**	**942,045.0**	**5.4%**	**800,495.0**	**4.1%**
Other Medical	**1,089,228.9**	**7.7%**	**1,313,075.2**	**7.5%**	**1,492,975.2**	**7.6%**
Laboratories	15,787.5	0. %	16,661.4	0.1%	45,965.1	0.2%
Transportation	43.379.1	0.3%	57,503.9	0.3%	151,464.5	0.8%
SMIB/HIB Expansion[4]	553,494.9	3.9%	598,333.0	3.4%	625,730.5	3.2%
Home Health Care/DSCC	141,330.4	1.0%	176,065.0	1.0%	199,094.4	1.0%
Appliances	32,445.5	0.2%	29,111.0	0.2%	25,567.0	0.1%
Other Related[5]	176,321.5	1.3 %	206,118.6	1.2%	230,884.0	1.2%
Community Health Centers	62,246.0	0.4%	55,439.9	0.3%	40,585.3	0.2%
Medically Complex Development (MCDD)[6]	0.0	0.0%	113,590.7	0.7%	123,440.2	0.6%
Hospice Care	64,224.0	0.5%	60,251.7	0.3%	50,514.2	0.3%
Managed Care	**9,603,826.5**	**68.2%**	**12,961,999.5**	**74.5%**	**15,521,031.5**	**79.2%**
Children's Health Rebate	**0.0**	**0.0%**	**0.0**	**0.0%**	**0.0**	**0.0$**

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

[2] Provider line expenditures excludes administrative appropriation 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 2021.

Annual Report Statutory Requirements

The Department issues this Annual Report under four statutory requirements:

Illinois Public Aid Code (305 ILCS 5/5-5) requires the Department to report annually no later than the second Friday in April, concerning:

- actual statistics and trends in utilization of medical service by Public Aid recipients;
- actual statistics and trends in the provision of the various medical services by medical vendors;
- current rate structures and the proposed changes in those rate structures for the various medical vendors; and
- efforts at utilization review and control by the Department of Public Aid.

Illinois Public Aid Code (305 ILCS 5/5-5.8) requires the Department to report annually to the General Assembly, no later than the first Monday in April, in regard to:

- the rate structure used by the Department to reimburse nursing facilities;
- changes to the rate structure for reimbursing nursing facilities;
- the administrative and program costs of reimbursing nursing facilities;
- the availability of beds in nursing facilities for Public Aid recipients; and
- the number of closings of nursing facilities and the reasons for those closings.

Illinois Public Aid Code (305 ILCS 5/11-5.4) requires the Department to report to the General Assembly as part of the Medical Assistance Annual Report the status of applications for LTC services.

Disabilities Services Act of 2003 (20 ILCS 2407/55) requires the Department to report annually on Money Follows the Person, no later than April 1 of each year in conjunction with the annual report, concerning:

- a description of any interagency agreements, fiscal payment mechanisms or methodologies developed under this Act that effectively support choice;
- information concerning the dollar amounts of State Medicaid long-term care expenditures and the percentage of such expenditures that were for institutional long-term care services or were for community-based long-term care services; and
- documentation that the Department has met the requirements under Section 54(a) to assure the health and welfare of eligible individuals receiving home and community-based long-term care services.