FY 2024 Annual Report

Medical Assistance Programs

April 01, 2025

JB Pritzker, Governor
Elizabeth M Whitehorn, HFS Director

HFS
Illinois Department of Healthcare and Family Services

Letter From the Director

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

On behalf of the Illinois Department of Healthcare and Family Services (HFS), I am pleased to present the Fiscal Year (FY) 2024 Medical Assistance Programs Annual Report, detailing our efforts to bring accessible, high-quality healthcare and essential support services to the residents of Illinois. Over the past year, we have remained steadfast in our commitment to strengthening the Medicaid program by implementing a range of innovations and advances that are bringing improved care to those we serve.

Key Achievements in FY 2024

- **Medicaid Redetermination and Unwinding.** Following the end of the federal pandemic-era continuous coverage requirement, HFS worked to ensure eligible customers maintained Medicaid coverage through the completion of a multi-platform outreach campaign. As a result, Illinois had among the highest renewal rates nationally.

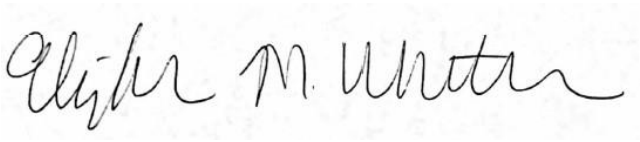
- **Healthcare Equity Initiatives**. We focused on building and implementing programs aimed at reducing disparities in healthcare, particularly in underserved communities. Notable progress includes obtaining federal approval for the Healthcare Transformation 1115 Demonstration waiver to address health-related social needs and launching the Medical Debt Relief Pilot Program, which has already relieved more than $345 million in medical debt for Illinois families.

- **Improving Access to Care**. HFS worked to enhance access to essential healthcare services, particularly in the areas of behavioral health and maternal health with the addition of coverage for perinatal doula and lactation consultant services and the creation of an Illinois Certified Community Behavioral Health Clinic Program. With sister agencies, HFS also continued advancing the work of the Children's Behavioral Health Transformation Initiative to strengthen and improve behavioral health services for youth.

Looking Ahead

In FY 2025, HFS will continue to build upon these successes, advancing policies that promote health equity, modernizing our systems for better service delivery, and ensuring that every Medicaid customer has access to the care they need. Achieving these successes would not be possible without the dedication and hard work of the HFS staff. Their commitment to serving the people of Illinois – whether through policy development, customer service, or behind-the-scenes operations – has been instrumental in driving our progress. I want to extend my sincere appreciation to every member of our team for their unwavering focus on our mission.

We remain committed to working in partnership with the General Assembly and our stakeholders to achieve our shared goal of making Illinois a leader in transformative, high-quality healthcare.



Elizabeth M. Whitehorn, Director

1

Overview

MISSION

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

VISION

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

VALUES

- Integrity
- Public Service
- Quality
- Equity
- Teamwork
- Health and Happiness

WE IMPROVE LIVES.

The Illinois Department of Healthcare and Family Services (HFS) administers the medical assistance programs most known as Medicaid, the Children's Health Insurance Program (CHIP), and All Kids. These programs are jointly funded by the state and federal government and provide critical healthcare coverage to nearly 3.5 million individuals and families across Illinois.

HFS administers its medical assistance programs under the Illinois Public Aid Code (305 ILCS 5/), the Children's Health Insurance Program Act (215 ILCS 106/), the Covering ALL KIDS Health Insurance Act (215 ILCS 170/), and Titles XIX and XXI of the federal Social Security Act (SSA).

Eligibility and Enrollment

Eligibility for the medical assistance programs is generally based on income, household size, and other factors. Categories of individuals who may qualify include:

- Low-income families;
- Pregnant women;
- Children under 19;
- Adults ages 19-64 with limited income;
- Seniors age 65+;
- Individuals with disabilities;
- Foster children and those in adoption assistance.

Income limits vary by category and are determined based on federal poverty levels (FPL). A comprehensive overview of all medical assistance program coverage types is included in Appendix II of this report.

Enrollment Numbers

The HFS medical assistance programs serve as the largest health insurer in Illinois. In FY 2024, HFS provided medical coverage to more than 25% of the state's population. Enrollment as of June 30 for the last three completed fiscal years (Illinois' fiscal year is July 1 to June 30) is as follows:

Comprehensive Benefits	FY 2022	FY 2023	FY 2024
Children	1,499,514	1,542,115	1,487,024
Adults with Disabilities	246,842	250,817	232,198
ACA Newly Eligible Adults	868,108	939,005	772,233
Other Adults	741,991	867,262	624,597
Seniors	288,600	336,269	295,617
Total Comprehensive	3,645,055	3,935,468	3,411,669
Partial Benefit Enrollees	47,275	46,499	51,204
Total Enrollees	**3,692,330**	**3,981,967**	**3,462,873**

Program Costs

During FY 2024, HFS spent approximately $36.58 billion (all funds), of which $26.51 billion was from the General Revenue Fund (GRF) or GRF-related funds for customer health benefits and related services. Please refer to Appendix IV for HFS FY 2024 spending by appropriation line.

Factors Impacting Program Costs

A summary of the factors contributing to the most significant changes in medical assistance program spending from FY 2022 – FY 2024 is provided below.

FY 2022

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

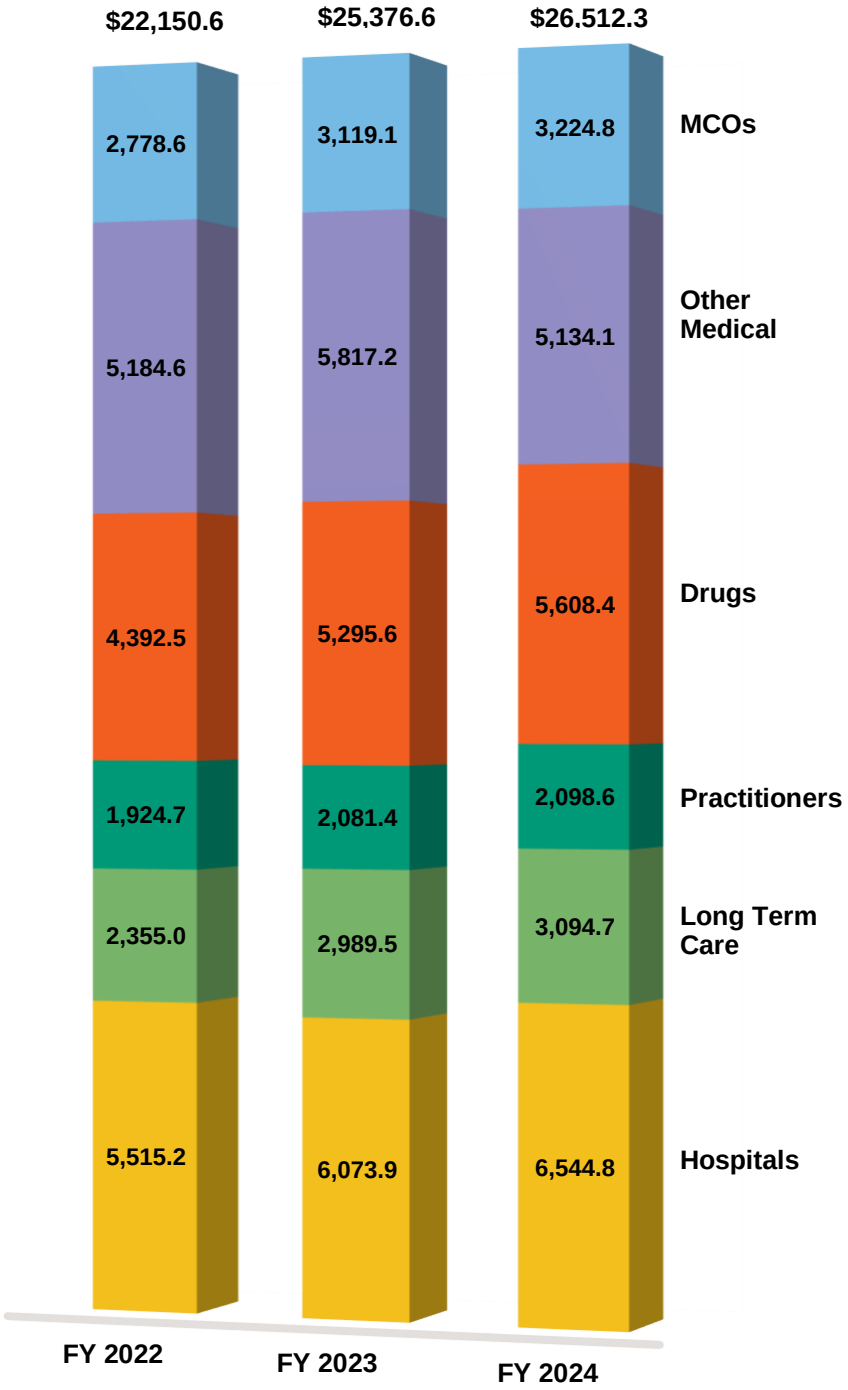
FY 2023

- In FY 2023, enrollment continued to increase during the PHE by over 6.5%.
- The Health Benefits for Immigrant Adults and Seniors (HBIA/S) programs continued to enroll customers, which reflected an increase within FFS claiming.
- Medicare Part D clawback increased due to CY 2023 rate and enrollment increases.
- Hospitals and community mental health providers received one-time pandemic stabilization payments, supported by American Rescue Plan Act funding, totaling $490 million. .

FY 2024

- Redeterminations began to take effect; however, increased acuity amongst the remaining population continues to drive liability increases.
- Medicare Part D clawback increased due to CY 2024 rate and enrollment increases.

Medical Programs Spending FY 2022 – FY 2024
(dollars in millions)



Notes:

Not included in total spending are expenditures from the (Cook) County Provider Trust, University of Illinois Hospital Services, non-entitlements, Hospital Provider Fund (relating to the assessment), Trauma Center, Special Education Medicaid matching, Money Follows the Person budget transfer, Electronic Health Record Incentive, Medicaid Buy-In, Medical Special Purposes Trust, Medical

Interagency Program, Juvenile Rehabilitation Services, and Coronavirus Urgent Remediation Emergency Funds.
MCOs includes administrative fees and approximately $1 billion in reimbursements to Medicaid MCOs for their portion of managed care assessment tax (cost of doing business) to effectuate federally required actuarily sound capitation rates. MCO capitations are generally allocated to provider types (Other Medical, Drugs, Practitioners, Long Term Care and Hospitals) based upon that fiscal year's MCO encounter data.
"Other Medical" refers to Laboratories, Transportation, Medicare A & B Premiums, Home Health Care/Division of Specialized Care for Children (DSCC), Appliances, Other Related Supplies and Equipment, Community Health Centers, Medically Complex for the Developmentally Disabled (MC/DD), and Hospice Care.
Numbers may not appear to add due to rounding.
Graph Prepared By: Division of Finance
Data Source: Division of Finance, Comptroller Spending Report FY'22-'24.

2

Addressing Health Disparities

Addressing Health Disparities

HFS aims to provide every community and population what is needed to succeed so everyone can reach their full potential. Long-standing social and structural inequities continue to have a drastic impact on health; studies estimate that clinical care impacts only 20% of a population's health outcomes, while social and structural determinants of health (SSDOH) affect as much as 50%.

> Social and structural determinants of health are estimated to account for up to 50% of health outcomes.

HFS is focused on reducing health disparities by addressing our customers' health-related social needs (HRSNs). HRSNs are specific, individual needs that arise from SSDOHs and can directly impact a person's health, such as affordable housing, food insecurity, lack of transportation, financial hardship, and language barriers. This section highlights some of the initiatives HFS and its partners are undertaking to advance health equity, improve health outcomes, and improve well-being for Medicaid customers.

Healthcare Transformation Collaboratives: Partnerships for Community Innovation

The innovative **Healthcare Transformation Collaboratives** (HTC) program was launched in 2021, with the aim to close gaps in healthcare services and eliminate barriers to access and inequities in the state's healthcare system. Illinois healthcare providers partner with one another to form collaboratives that further these goals in their communities. The HTCs leverage their shared resources to create strategies for improving access, quality, and equity in the healthcare landscape. These initiatives underscore a transformative approach to community health, blending medical care, social support, and targeted outreach to ensure long-term impact.

HFS has overseen the creation of 15 HTCs throughout Illinois, announced during 2 rounds in 2021 and 2022. HFS is authorized to spend up to $150 million annually on the program with support from federal matching funds.

HTCs by the Numbers:

- Nearly 500 employees hired
- 30,000 customers received care for chronic conditions such as hypertension, asthma, mental illness, and heart failure
- 10,000 preventive clinical screenings completed
- 40,000+ specialty care visits delivered

HTC FY 2024 Successes

- In the summer of 2024, the **Center for Better Aging (CBA)** had its soft launch at St. Bernard Hospital on Chicago's South Side. Anchored at this independent community hospital, the CBA provides comprehensive healthcare services, including primary and specialty care, a certified emergency department for older adults, advanced diagnostics, a geriatric pharmacy, and more, all conveniently located on a single medical campus.
- April 2024 marked the grand opening of Chestnut Family Dental, a new initiative under the **Medicaid Innovation Collaborative (MIC)**. Around the same time, the MIC OnCall Connect Mobile Care Van began operations in Alton, where it served 630 customers between April and June 2024. Meanwhile, Rockford's mobile van, which launched in September 2023, served 827 patients by the same date. These mobile care vans deliver services such as virtual urgent care visits, free health screenings, SSDOH assessments, referrals to community-based organizations (CBOs), navigation services, and patient education.
- In December 2023, the **East St. Louis Collaborative** launched its urgent care services, which saw a significant impact by June 2024. Over 2,691 patients were served, with 549 lab services and 349 imaging services provided. Due to high demand in targeted zip codes, hours of operation were expanded to accommodate the needs of the community.
- The **Collaborative Bridges Wellness Center** in West Garfield Park broke ground in May 2024. This 17,000-square-foot facility is designed to support individuals facing mental and behavioral health challenges, addressing a critical need in the area.

Nursing Home Rate Reform

Each year, HFS spends billions of dollars on nursing facility care for approximately 45,000 Medicaid customers. Medicaid pays for approximately 68% of all nursing facility days in Illinois and is the largest payer of days in both the state and across the nation. Medicaid customers, especially Black and Brown nursing home residents, are more likely to live in understaffed facilities, making equity a driving force behind the need for change.

In 2022, Illinois enacted comprehensive nursing home rate reforms to enhance the quality of care for Medicaid customers by increasing funding, improving staffing levels, and ensuring greater transparency within nursing facilities. The reform package included the following key changes:

- **New nursing home assessment.** The nursing home bed tax was streamlined from a two-pronged tax comprised of $6.07 per occupied bed day plus $1.50 per licensed bed to a single tax with a variable rate based on Medicaid resident days. This change resulted in an increase of the state's taxing authority to nearly 6% of total revenue, providing additional revenue to help fund the reform's staffing and quality initiatives.

- **Adoption of a Patient-Driven Payment Model (PDPM).** Illinois transitioned from the Resource Utilization Group (RUG) methodology to the PDPM, a case-mix methodology designed to reflect the clinical care needs of residents more accurately. This model mitigates financial incentives related to the volume of services provided, focusing instead on the individual needs of each resident.

- **Linking payment to staffing levels.** A new add-on payment is now included in the rate calculation based on a facility's Staff Time Resource Intensity Verification (STRIVE) staffing level. The add-on rewards facilities with sufficient and sustained levels of staffing, while still providing support and incentive for lower staffed facilities to invest in new staff.

- **Pay scale for Certified Nursing Assistants (CNAs).** Although CNAs play a pivotal role in the day-to-day care of nursing facility residents, often serving as the primary caregivers and the frontline of patient interaction, their compensation has not historically reflected the importance and demands of their work. The reform introduced a unique payment program that reimburses providers for the Medicaid portion of retention and promotion-based wage increments for CNAs, most rewarding long-serving CNAs.

- **Rewarding quality and performance.** Increased staffing is expected to improve quality, but to further incentivize nursing facilities providing safe and high-quality care, Illinois established a Quality Incentive Payment program that annually distributes $70 million based upon federally published Medicare Star ratings. Providers must receive at least a 2-Star rating to receive funding. As provider long stay Star ratings increase, they receive a higher proportion of the pooled funding.

An interim review of the 2022 payment reforms indicated that increased funding led to a 27%rise in nursing home reimbursement in FY 2023. It is projected that reimbursement to nursing facilities will increase by more than $650 million in FY 2024 over pre-reform levels.

Illinois Healthcare Transformation Section 1115 Demonstration Waiver

In FY 2024, HFS advanced its commitment to an equitable and sustainable healthcare delivery system by seeking an extension and amendment to its Behavioral Health Transformation Section 1115 Demonstration Waiver, originally approved in 2018. This initiative, now renamed the Illinois Healthcare Transformation Section 1115 Demonstration, aims to broaden its scope beyond behavioral health to address critical health related social needs (HRSNs).

On July 2, 2024, HFS received federal approval to extend the Illinois Healthcare Transformation Section 1115 Demonstration Waiver through June 30, 2029. The approval allows for the continuation of services implemented under the 2018 version of the 1115 Demonstration Waiver, which includes substance use disorder (SUD) treatment for individuals in Institutions for Mental Diseases (IMDs) and SUD case management. The expanded Demonstration also includes authority for new services such as housing supports, employment assistance, medical respite, food and nutrition services, violence prevention and intervention, non-medical transportation, and community reintegration for individuals transitioning from incarceration or institutional settings. These new services will be designed to bring sustainable, community-driven solutions to some of Illinois' most vulnerable residents and incorporate non-traditional providers into the Medicaid program.

What's Ahead?

Work to plan the implementation of the Demonstration will be a heavy focus for HFS in FY 2025, with initial implementation efforts focusing on reentry services and housing and nutrition supports. HFS will continue engaging with sister agencies and external stakeholders, including CBOs and providers involved in social services, healthcare, housing, and food security, on a variety of implementation-related tasks to develop and establish operational protocols.

Health Equity Efforts within Managed Care

- **Equity Directors.** Each MCO employs an equity director who is responsible for the strategic design, implementation, and evaluation of health equity efforts within their organization. This includes overseeing and providing input into MCO practices related to disparity reductions and ensuring demographic data is being collected and meaningfully applied to identify and reduce disparities.
- **SSDOH Work Plans.** Annually, MCOs submit an SSDOH Work Plan to HFS that outlines how the MCO will identify, evaluate, and reduce (to the extent practical), health disparities based on factors such as age, race, ethnicity, gender, primary language, and disability status. The SSDOH Work Plans include:

    - A strategy that adopts a whole person care approach through the provision of SSDOH resources at the customer and community levels.
    - A cultural competence plan with targeted efforts to address and mitigate disparities and cultural gaps.
    - Analytic methods to identify, monitor, and address unmet social needs.
    - A plan to increase awareness of and access to community-based SSDOH supports and resources.
    - Development of targeted strategies to address the SSDOH needs of special populations disproportionately impacted by SSDOH and at high risk for adverse health outcomes.
    - Promotion of statewide collaboration with other MCOs, HFS, other state agencies, and community partners in implementing SSDOH strategies.
- **Stratified Performance Measure Data.** MCOs have begun reporting performance measure data against a set of stratification criteria that includes, but is not limited to race, ethnicity, geography, eligibility category, age, and gender.
- **Quarterly Equity Discussions.** Quarterly equity discussions are inclusive of MCO quality programs and their health equity directors. Each quarter focuses on a discussion and analysis of different stratified performance measures. These analyses help MCOs identify equity gaps, advance health equity efforts within their SSDOH Plans, further the work overseen by the health equity director, and incorporate customer feedback through their advisory committees.
- **Health Plan Investments.** MCOs continue to invest in critical services and initiatives to help address disparities and build capacity in underserved areas. These investments include increasing reimbursement rates for behavioral health providers, expanding telehealth capabilities and infrastructure, increasing community engagement in Black, Brown, and Latin communities by contracting with Business Enterprise Program (BEP) organizations, providing technology assistance, extending housing benefits; and continuing to provide food and funding to school-based health centers**.**

Medical Debt Relief Program

The Medical Debt Relief Act (305 ILCS 85/), passed in spring 2024, charged HFS with establishing a Medical Debt Relief Pilot Program to alleviate medical debt burdens for low-income Illinois residents. This nation-leading program reflects Illinois' ongoing commitment to improve health equity Medical debt disproportionately affects people of color - Black Illinoisans are 50% more likely to accrue medical debt than their white peers.

$10 million in state funding has been allocated to potentially erase up to $1 billion in medical debt. This will be achieved by purchasing outstanding debts from healthcare providers and forgiving them at no cost to the individuals. In FY 2025, HFS will be working with Undue Medical Debt, a national nonprofit, to establish partnerships with health systems and providers to sell or donate qualifying debt portfolios.

HELP FOR A NEW MOM

Natalie gave birth to a premature baby boy when she was 32 weeks pregnant. Her baby spent time in the neonatal intensive care unit (NICU) due to complications, including trouble with feeding. Due to the baby's extended stay in the NICU, Natalie was not able to work and was at risk of losing her apartment. Natalie worried she would not have a place to bring her baby home and shared her situation with her MCO Care Coordinator, who sprang into action.

Natalie was referred to Legal Aid Chicago, signed up to receive nutritional support and money for groceries, and received follow-up support for all the appointments for her and her baby. With the help of Legal Aid Chicago and other eviction prevention resources, Natalie and her landlord came to an agreement for her to stay in the apartment while she looked for a new place to live. Thanks to the support Natalie received from her MCO Care Coordinator to maintain stable housing, she is happy to report that she secured a part-time job and is on track with the rent at her new apartment.

Executive Order on Financing and Access for Sickle Cell Disease Treatment and Other High-Cost Drugs and Treatment

Sickle cell disease is a group of lifelong inherited blood disorders that disproportionately impacts people of color, particularly Black Americans, leading to a higher risk of chronic and life-threatening conditions as well as a life expectancy more than 20 years shorter than the general population.

In December 2023, the U.S. Food and Drug Administration (FDA) approved 2 milestone gene therapies for the treatment of sickle cell disease. This follows an emerging trend of novel cell and gene therapies that are being approved by the FDA. The high cost of these therapies, which can

exceed $2 million per patient, creates a growing concern about equitable access to potentially life-saving treatments. Despite these concerns, the importance of equitable access to novel therapies for historically underserved populations is clear.

As such, in March 2024, Governor Pritzker signed Executive Order 2024-01 to tackle these challenges head on, with the goal of finding innovative solutions to enhance access to treatments for sickle cell disease and other high-cost therapies. The Executive Order directs HFS to develop payment models and financial structures within the Medicaid program to support equitable access to these transformative treatments. It also establishes the Advisory Council on Financing and Access to Sickle Cell Disease Treatment and Other High-Cost Drugs and Treatment. The council is tasked with reviewing innovative payment approaches, focusing on value and outcome-based models, and providing recommendations to HFS.

3

Access to Care

COVID-19 Public Health Emergency Unwinding

The COVID-19 Public Health Emergency (PHE) officially ended on May 11, 2023. During the COVID-19 PHE, the federal government implemented a continuous coverage requirement within the Medicaid program, ensuring that Medicaid customers maintained their healthcare coverage without needing to undergo annual eligibility checks, also known as redeterminations or renewals. As of April 1, 2023, the continuous coverage requirement ended and states began the process of redetermining eligibility for all Medicaid customers – a process known as "unwinding." **During the unwinding, Illinois experienced an eligibility retention rate of 78%, one of the highest in the nation**.

The success is attributed to HFS' comprehensive outreach initiatives, such as the "Ready to Renew" campaign, which utilized various communication platforms to inform and assist Medicaid customers. Additionally, HFS launched the "Are You Covered?" messaging toolkit in multiple languages to further support the renewal process. However, the positive impact would not have been possible without the support and partnership between HFS, sister state agencies, MCOs, community organizations, healthcare providers, and advocates who supported outreach and education efforts. Special gratitude is owed to the thousands of front-line workers who helped individuals and families navigate the renewal process. Together, these efforts ensured that eligible individuals maintained their healthcare coverage during the transition period.

Provider Rate Increases

In FY 2024, HFS implemented **over $1.1 billion in annual provider rate increases** across various covered healthcare services with the goal of supporting increased access to care and stabilizing the Medicaid provider workforce. Key reimbursement increases include:

- **Hospital Services.** More than $550 million was invested in increasing reimbursement to hospitals, including a 10% increase in inpatient and outpatient service rates and enhanced support for safety net hospitals, inpatient psychiatric providers, and freestanding children's hospitals.
- **Long Term Care Facilities.** Nursing facilities are estimated to be receiving an additional $143 million because of a 12% increase to the support component of their rate as well as increases to the ventilator add-on rate. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Medically Complex for the Developmentally Disabled (MC/DD) facilities, and associated Developmental Training providers received an estimated $54.4 million in rate increases to implement a $2.50 per hour wage increase for direct support and other frontline personnel as well as to support increases to the exceptional care per diem rates.
- **Physician Services.** Physician rates were raised from generally reimbursing at 60% of Medicare to 70% of Medicare, with a reimbursement ceiling set at 100% of Medicare for all services but behavioral health and non-cesarian obstetrical services. These changes resulted in a nearly $121 million annual increase for practitioners.

- **Federally Qualified Health Centers (FQHCs).** $50 million was invested in increasing FQHC encounter rates by 11%.
- **Behavioral Health Services.** Community mental health and SUD services received more than $48 million in rate increases, inclusive of a 30% increase for SUD residential services.
- **Transportation Services**. Air transportation and ambulances rates were increased by nearly $44 million annually.
- **1915(c) Waiver Services.** Approximately $75 million was invested in rate increases to support many of the state's 1915(c) home-and-community-based services (HCBS) waivers.

Additional rate increases were also implemented to support services under the Early Intervention program, durable medical equipment, and therapy services.

Community Mental Health Access Payments

In FY 2024, HFS and its contracted MCOs issued more than $50 million in access payments to community mental health providers. Using Medicaid claims data, HFS calculated the amount to be issued to each eligible provider using criteria outlined in legislation (PA 102-0699 and PA 102-1118). HFS issued payments directly to eligible providers for FFS program customers, while MCOs issued directed payments to the HFS-identified eligible providers for services delivered to their members. The 3 types of access payments are described below.

- **Assertive Community Treatment (ACT) Access Payments**. Providers of ACT services received an annual payment of $6,000 for each customer to whom the provider delivered minimally 300 units (75 hours) of ACT services during a baseline measurement year.
- **Community Support Team (CST) Access Payments**. Providers of CST services received an annual payment of $4,200 for each customer to whom the provider delivered minimally 200 units (50 hours) of CST services during a baseline measurement year.
- **One-time directed payment.** A one-time directed payment was issued to support assessment, treatment planning, crisis services, medication monitoring, family therapy, ACT, CST services delivered by community mental health providers. These funds also supported providers delivering services to Youth in Care.

Improving Maternal and Infant Health

Illinois' commitment to improving birthing outcomes and addressing racial disparities is reflected in the efforts to expand access to supportive services undertaken in FY 2024.

- **Launch of Illinois Medicaid-Certified Doula Program.** In partnership with the Southern Illinois University (SIU) School of Medicine, HFS launched a certification program for doulas seeking to deliver services to Illinois Medicaid customers. This Illinois certification, developed in partnership with HFS and a workgroup of community doulas, leverages an extensive list of existing national and Illinois-based doula training programs and includes a training-based pathway as well as a legacy pathway for doulas with significant experience.
- **Expanded coverage to include doulas.** Doulas provide physical, educational, and emotional support during pregnancy, childbirth, and the postpartum period, aiming to improve health outcomes for both parent and child.
- **Expanded coverage to include lactation consultants.** Lactation consultants offer breastfeeding education and support.
- **Standing recommendation for doula and lactation services.** Illinois issued a standing recommendation for lactation services and doula services so that Medicaid customers can receive coverage for these services without having to obtain a referral from their physician. This standing recommendation meets a federal requirement that preventive services provided by certified doulas and certified lactation consultants be recommended by a licensed provider. It removes a potential access barrier for Medicaid customers and removes an administrative burden from lactation consultants and doulas.

During the reporting period, HFS also began meeting with stakeholders to plan for the implementation of additional maternal and child health focused provider types and services. This includes licensed and certified professional midwives, evidence-based home visiting programs, medical case workers, and community health workers.

SUPPORTING NEW FAMILIES

A Community Health Worker (CHW) at a health center in Southern Illinois received a call from a mother requesting an appointment for her newborn baby. During the conversation, the CHW identified the baby was co-sleeping with the parents in an adult bed, indicating an unsafe sleeping arrangement, and that the family was experiencing food insecurity. Without delay, the CHW enrolled the mother in safety sleep classes and arranged a Zoom connection. Both parents attended the presentation and within an hour, the father arranged to collect a pack 'n play in coordination with the local Healthy Start program. The CHW also connected with the Salvation Army to help get food delivered to the new family the following morning.

Increasing Support to School Districts

The School-Based Health Services (SBHS) program is a partnership between HFS and school districts (also referred to as local education agencies, or LEAs) that promotes the overall well-being and academic success of students by facilitating access to healthcare services. This partnership allows LEAs to receive Medicaid reimbursement for a portion of the costs incurred to provide administrative and direct medical services to Medicaid enrolled students.

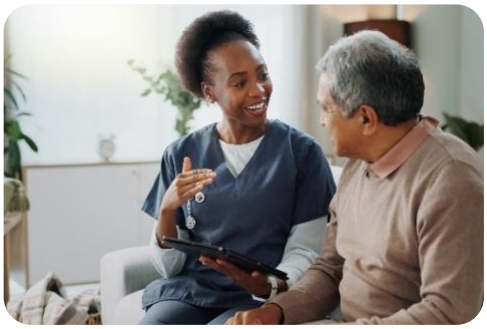
880+ LEAs participate in the SBHS program.
In FY 2024, the program served approximately 244,000 Medicaid enrolled students.

Direct medical services covered under the program include preventive care, nursing, mental health, physical therapy, occupational therapy, speech-language services, school health aides, and other services covered by the Medicaid program. Public Consulting Group (PCG) supports HFS in the administration of SBHS and provides ongoing training, support, and technical assistance to LEAs, including maintaining training resources on their website.

In April 2023, Illinois received federal approval to expand the SBHS program to cover services for all Medicaid-enrolled students. Historically, LEAs were only able to receive federal reimbursement for services provided to Medicaid-enrolled students who had an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP), which meant reimbursement for Medicaid services in schools was limited to a small group of children. When federal CMS changed this policy, it allowed more children to receive needed services in a school setting with federal matching dollars.

The recent federal approval also updated the reimbursement methodology for LEAs, shifting to an annual cost-settlement process designed to increase funding to schools by reimbursing LEAs based on their actual costs for delivering care.

FY 2022 was the first fiscal year of reimbursements under the cost-settlement process and was also the first year that included services for the expanded population of students. Cost-settlement was completed in June 2024, **resulting in a total reimbursement to LEAs of nearly $267 million** for FY 2022 services. Of this total, approximately $92.8 million was a result of moving to the cost-settlement reimbursement methodology while $17.8 million in reimbursement came from services to the expanded population of students.



STAN'S STORY

Thanks to PACE, 70-year old Stan has enjoyed newfound health improvements and overall well-being after experiencing an ongoing history of hospitalizations and stays in skilled nursing facilities, battling issues like chronic, unhealed wounds.

PACE was contacted about Stan while he was still in skilled care, with the hope of discharging him to home healthcare; however, he lived alone without immediate family support and was unable to drive. Through PACE, Stan began attending adult day center programming, receiving regular wound care, and getting nutritional advice and dietitian-tailored meals to improve his ability to heal.

In just 3 short months, he has made remarkable progress in closing his existing wounds and maintaining his skincare. In addition, he has not had any emergency episodes and has been able to avoid an extensive vascular surgery thanks to the comprehensive, team-based care offered though OSF PACE.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a new model of care in Illinois that offers comprehensive health services for seniors living in the community who would otherwise qualify to live in a nursing facility. This approach gives seniors an additional choice in how they access healthcare as needs change with age, allowing more seniors to continue living at home safely, for longer.

PACE organizations are responsible for providing care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year. The PACE center includes a primary care clinic and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and serves as the focal point for coordination and provision of most PACE services.

Based on a market analysis, HFS developed 5 service regions for PACE: West Chicago, South Chicago, Southern Cook County, Peoria, and East St. Louis. Three PACE organizations began providing services in July 2024, with 2 additional organizations planning to become operational in 2025.

Certified Community Behavioral Health Clinics

Certified Community Behavioral Health Clinics (CCBHCs) represent a new model of behavioral healthcare that provides comprehensive, integrated mental health, SUD, and primary care screening and monitoring services to anyone who presents for care,

regardless of age, residence, or ability to pay. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their actual costs of providing services to meet the needs of these complex populations.

In FY 2024, HFS made significant progress towards implementing an Illinois CCBHC program. Key activities included the release of the CCBHC provider application in August 2023, resulting in 25 out of 34 provider sites being approved to pursue certification. In December 2023, the certification process began, with 19 providers receiving provisional certification to implement state and federal CCBHC requirements. HFS also established a statewide CCBHC Advisory Committee in October 2023, led by the Chief Behavioral Health Officer (CBHO), to gain feedback from providers and Medicaid customers to guide the program's development.

In March 2024, HFS applied to participate in the 2024 cohort of the CCBHC Medicaid Demonstration Program (Demonstration), authorized by Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 and administered jointly by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS). Illinois was notified in June 2024 it was 1 of 10 states selected to join the CCBHC Demonstration. HFS' participation in the CCBHC Demonstration aims to further prioritize and enhance person-centered treatment while optimizing the state's behavioral health service delivery system.

FY 2025 efforts will focus on establishing the systems, policies, and technical assistance needed to support Illinois' 19 certified CCBHCs in early adoption and implementation of the CCBHC model.

Pathways to Success

Pathways to Success is a program that supports Medicaid-enrolled children under the age of 21 with complex behavioral health needs by providing access to intensive home-and-community-based services. The goal of the program is to strengthen family stability, improve clinical outcomes, and promote the use of community-based services, ensuring children receive support in the least restrictive setting possible. By focusing on individualized care and community integration, Pathways to Success strives to help children succeed at home, in school, and within their communities.

Central to the program is the provision of an evidence-informed model of care coordination by specialized providers known as Care Coordination and Support Organizations (CCSOs). CCSOs provide 2 tiers of care coordination, based on the intensity and complexity of the needs of the child and their family: high fidelity wraparound for the most complex needs and intensive care coordination for those with significant needs. The program also covers additional services including intensive home-based care, family peer support, therapeutic mentoring, and respite care to support the needs of the child and their family.

HFS took a gradual approach to enrolling youth into the Pathways to Success program, allowing for more consistent monitoring of the quality of care coordination and other services. From the start of the program's implementation in December 2022 through the end of FY 2024, 4,183 children had been referred to the Pathways to Success program.

Enhancing Community Behavioral Health Services

Under the American Rescue Plan Act (ARPA) of 2021, HFS sought funding applications to enhance community-based behavioral health services, focusing on improving access in underserved areas and expanding intensive, team-based services. The funding opportunities were intended for organizations that wished to open new behavioral health clinics (BHCs) or community mental health centers (CMHCs) in underserved regions, or for existing providers to expand their services, particularly those involving ACT, CST, Violence Prevention CST (VP-CST), and services under the Pathways to Success program.

HFS released a Notice of Funding Opportunity (NOFO) in February 2024 to providers interested in doing intensive community-based services. As a result of this NOFO, $38.2 million was awarded to 40 providers across the state to support the development of needed behavioral health services.

Illinois DocAssist

The Illinois DocAssist program was implemented by HFS in collaboration with the Department of Psychiatry at the University of Illinois Chicago (UIC) to address access and capacity issues related to child and perinatal psychiatry in the Illinois Medicaid program. The program provides free pediatric and perinatal psychiatric and behavioral health consultation services to primary care providers (PCPs) and allied providers throughout the state. The consultation services are designed to support PCPs serving non-emergent youth and perinatal women with complex behavioral health and pharmacologic issues in a variety of practice venues such as school-based health centers, schools, private practices, group practices, health care centers, public health clinics, and with a variety of practitioners like physicians, nurse practitioners, nurses, physician assistants, and social workers.

The program's focus in 2024 has been on expansion to new users and geographic areas through marketing and partnerships. During this time the program provided 379 mental health consultations to healthcare providers across the state of Illinois, which was a 4.5% decrease in consultations from 2023 (397 consults). However, the program saw 20% growth in consultations in all regions of the state outside of Cook County and a 100% increase in use by advanced practice registered nurses (APRNs). This growth reflects intensified prioritization to reach clinicians who are providing care in historically low utilization areas.

In addition, during 2024 Illinois DocAssist provided educational events virtually and in person on a variety of relevant mental health topics. A total of 307 providers were trained in methods for screening, diagnosing, and treating mental health conditions over the year and a total of 1,449 providers were trained in Illinois DocAssist's service offerings and how to use them in practice.

The program also concluded its second year participating in a Health Resources and Services Administration (HRSA) grant supporting pediatric mental health care access, along with collaborating partner agencies. Through these grant efforts, consultations for children and youth ages 0-21 are expected to increase 10% for each of the 4 grant years with an emphasis on underserved/high needs counties.

Expansion of Supportive Living Program for Dementia Care Settings

The Supportive Living Program (SLP) is administered by HFS and operates under a 1915(c) HCBS waiver, which allows Medicaid funds to pay for assisted living services for eligible participants who might otherwise live in a nursing home. The goal of the SLP is to help residents remain in the community and to prevent or delay institutionalization. Seniors and persons with physical disabilities can maintain a more independent lifestyle in their own apartment while receiving support services such as routine health assessments by licensed nurses, social and health promotion, personal care assistance, meals, laundry, housekeeping, and 24-hour staff response. The resident is responsible for paying the cost of room and board at the facility.

At the end of 2023, HFS announced the approval of 11 applications to proceed towards certification to provide SLP Dementia Care Setting (DCS) services. SLP DCSs allow individuals ages 65 and older with Alzheimer's disease or other dementia the option of remaining in a community setting while providing the added safety intervention of delayed egress and other supports. In addition to services and requirements associated with conventional SLP settings, the DCS must provide 3 daily well-being checks and at least 3 daily scheduled activities. Without DCSs, many residents with moderate dementia would have to transfer to a more costly and institutional higher level of care to receive the services and safety interventions they require.

Upon meeting certification requirements to participate in the SLP as a DCS, the selected applicants are required to become operational within 180 days. By the end of FY 2024, 2 of the selected applicants had begun operations.

Other Medicaid Service Expansions

- **Expansion of Behavioral Health Professionals within Health Centers.** Effective January 1, 2024, coverage of behavioral health services within FQHCs and Rural Health Clinics (RHCs) expanded to allow graduate-level, sub-clinical behavioral health professionals to be reimbursed for services delivered under the supervision of a licensed clinician. This will allow health centers to better leverage the existing workforce, increasing the number of individuals who can be seen by behavioral healthcare providers and reducing wait times.
- **Over-the-counter (OTC) birth control.** HFS took steps to prepare for the release of the new OTC birth control pill, Opill, to ensure coverage for Medicaid customers without a prescription as soon as the pill was released in spring 2024. Pharmacies bill for the provision of the Opill under Illinois' standing order for hormonal contraceptives.
- **Transportation Network Companies (TNCs).** Effective November 1, 2023, HFS expanded its non-emergency medical transportation (NEMT) services to include TNCs, commonly referred to as ridesharing (e.g., Uber, Lyft). This enhancement made permanent a policy flexibility leveraged by MCOs implemented during the COVID-19 PHE and offers Medicaid customers more flexible transportation options for their medical appointments.
- **Genetic Counselors.** To promote greater access to services, HFS began allowing licensed genetic counselors to independently enroll and receive reimbursement as Medicaid providers as of April 1, 2024.

4

Collaboration & Provider Supports

Children's Behavioral Health Transformation Initiative

Established in March 2022 by Governor Pritzker, the goal of the Children's Behavioral Health Transformation Initiative (CBHTI) is to improve the delivery of behavioral health services to children and adolescents with significant and complex behavioral challenges. This initiative was planned as a means of streamlining and simplifying the ways in which families access resources, services, and support for the youth in their care. HFS has been an active partner in the initiative, participating in weekly Interagency Crisis Staffing Team calls to help families access behavioral health services that includes residential treatment, while also assisting in the overall development of the Blueprint for Transformation. The Blueprint, which outlines key recommended strategies, discusses aspects such as centralizing and streamlining children's behavioral health services, adjusting current capacity to better meet the needs of families who need behavioral health services, and promoting early intervention to help prevent not only the escalation of a youth's needs, but also the ultimate utilization of residential and inpatient psychiatric hospitalization.

In FY 2024, HFS participated in the development of the Behavioral Health Care and Ongoing Navigation (BEACON) care portal, a centralized resource for youth and families seeking mental health services that provides state agency support and connects them to community-based services. In addition, based on feedback gained through the CBHTI, HFS modified the Family Support Program (FSP) application so youth could be more easily identified as appropriate for the program and families could gain access to services and be connected with provider networks willing and able to help. The FSP provides access to intensive mental health services and supports to youth with severe emotional disturbances, with a goal of supporting eligible youth and their families by strengthening family stability, improving clinical outcomes, and promoting community-based services.

Unified Crisis Continuum

In 2023, leadership from across the Illinois Health and Human Service (IHHS) Departments participated in a year-long learning collaborative through the National Association for State Health Policy (NASHP). The Illinois team focused on developing a unified crisis continuum (UCC) that is streamlined and centered around individuals experiencing a behavioral health crisis. This work then transitioned into the initiatives required under the Strengthening and Transforming Behavioral Health Crisis Care (STBHCC) legislation, which established a

stakeholder committee that met across 7 meetings beginning in December 2023 and ending in August 2024. Through the course of these meetings, the committee arrived at a vision for an enhanced crisis system, which included an alignment of goals to help individuals in behavioral health crisis receive appropriate treatment as quickly as possible.

Upon the satisfaction of the STBHCC requirements in summer 2024, the work continued, transitioning under the portfolio title of the UCC. The UCC work continues today, including intergovernmental partnerships and a stakeholder committee to further develop a continuum that centers on:

- The experience of the customer and their support system,
- Simplification and standardization for providers,
- Braided funding that maximizes federal dollars,
- Accessible data and reporting technology, and
- Applying national best practices.

The current efforts are focused on developing a UCC strategic action plan that details the common vision of the IHHS Departments and stakeholders to standardize the crisis response all Illinoisans receive, regardless of insurance coverage or state payer system, while promoting financial sustainability, integrated healthcare, prevention, and equitable access to high-quality crisis care.

Medicaid Technical Assistance Center

The Medicaid Technical Assistance Center (MTAC) is a partnership between HFS and the University of Illinois, Office of Medicaid Innovation (OMI) that provides training, technical assistance, and support to Illinois Medicaid providers. Established by the Medicaid Technical Assistance Act of 2021 and formally launched in 2023, MTAC aims to assist and support community-based providers as they navigate enrollment and participation in the Illinois Medicaid Program, with the goal of increasing access to quality care for Medicaid customers across the state. Employing the experience and knowledge of 3 distinct MTAC teams (Outreach, Enrollment, and Assist), MTAC offers outreach, engagement, training, and one-on-one enrollment support for providers, regardless of their experience level with Illinois Medicaid. In FY 2024, MTAC supported providers through the following:

- **Certification of Behavioral Health Providers.** MTAC completed a total of 236 certification reviews for community behavioral health providers. This included the certification of 30 new BHCs and 19 CCBHCs. Additionally, MTAC supported HFS in the design and launch of the CCBHC certification review process in November 2023, including coordinating the review of applicants for participation in the CCBHC Demonstration.

- **Portal Management**. MTAC provided support to HFS by facilitating the management of 2 online portals, the MCO Complaint portal and the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) portal, while also monitoring and assisting with questions received through OMI's IM+CANS support email for providers.

- **Technical Assistance**. MTAC staff completed 366 technical assistance calls with providers, particularly community behavioral health providers and adaptive behavior support (ABS) providers. Technical assistance specific to the Pathways to Success program was introduced, effectively providing guidance to providers on services, provider enrollment, and service codes and billing details related to the program

- **Training**. MTAC worked with stakeholders to design a training and support program for new child and maternal health provider types, including doulas and lactation consultants. Development and planning of training materials for the coverage of licensed and certified professional midwives, planned for addition into the Medicaid service array in FY 2025, began in collaboration with HFS subject matter experts and external stakeholders. MTAC staff also implemented training-on-demand for BHCs and ABS providers interested in joining the Illinois Medicaid program. And finally, FY 2024 saw the development of the HFS training registry plus a detailed index of managed care contacts to allow providers to find information and assistance more efficiently.

Provider Assistance and Training Hub Expansion into Coaching

Launched in 2018, the Provider Assistance and Training Hub (PATH) is a partnership between HFS and the University of Illinois Urbana-Champaign School of Social Work (UIUC SSW) that provides free clinical training, consultation, and support to community behavioral health providers.

PATH BY THE NUMBERS

- 16,000+ participants registered for a training course
- 318 field specialist-led webinars delivered
- 7,718 self-paced courses completed
- 13,370 trainings completed
- 2,628 new IM+CANS users certified

Topics that PATH offers training on include crisis services and skill sets, clinical interviewing and engagement skills, care planning, safety considerations, compassion fatigue and vicarious trauma, and supervision and coaching. PATH also provides training and coaching on Pathways to Success services and on the Transformational Collaborative Outcomes Management (TCOM) framework and usage of TCOM tools, such as the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) and the Illinois Medicaid Crisis Assessment Tool (IM-CAT).

To promote a collaborative approach to high-quality wraparound and intensive care coordination as part of the Pathways to Success program, PATH engaged all CCSOs in coaching efforts in FY 2024. By implementing coaching in addition to training, PATH continues to play a crucial role in strengthening care systems to create safer, healthier communities and ensuring providers are supported in their implementation efforts.

IM+CANS Provider Workgroup

The IM+CANS is a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois. Developed through a collaborative effort between HFS, the Department of Human Services-Division of Mental Health

(DHS-DMH), and the Department of Children and Family Services (DCFS), the IM+CANS serves as the foundation for Illinois' publicly funded behavioral health service delivery system. The IM+CANS is essential for individual case planning and the planning and evaluation of service systems, supporting a customer-centered, data-driven approach to mental health treatment in Illinois.

To obtain provider input and feedback in improving the design and usage of the IM+CANS, HFS launched the IM+CANS provider workgroup in November 2021. The workgroup provided a series of recommendations to HFS related to policy, technology, clinical use, and tool design. In FY 2024, HFS implemented many of these recommendations, including:

- Publishing updated policy guidance regarding medical necessity and documentation requirements as it relates to the IM+CANS.
- Implementing suggested updates to make the IM+CANS tool more user-friendly as well as to streamline and consolidate the collection of vital information.
- Releasing updates to the web-based IM+CANS portal, both to align with the tool updates and to streamline data collection and submission processes for providers.

In FY 2025, the IM+CANS provider workgroup will continue to meet monthly to provide HFS with input on how to improve the IM+CANS and best support providers in its usage.

Direct Care Workforce Technical Assistance Grant

In May 2024, it was announced that Illinois was chosen as 1 of 14 states to join the Direct Care Workforce Strategies Center's new initiative led by the National Council on Aging (NCOA) to address the nationwide shortage of direct care workers. These workers, who provide essential home-and-community-based services to older adults and people with disabilities, have faced challenges that include low wages, lack of full-time employment, and pandemic-related difficulties, resulting in fewer workers entering direct care despite the need for their services continuing to grow. The selected states will participate in monthly peer-learning collaboratives to exchange resources and strategies aimed at expanding and retaining the direct care workforce to build sustainable solutions for the growing demand for caregiving professionals.

For Illinois' part, the state is participating in focused working groups with a milestone goal centered on training and curriculum to aid in the expansion and enhancement of the direct care workforce within Illinois. Along with the other partnering states, Illinois will work alongside the Direct Care Workforce Strategies Center, which provides technical assistance to states and service providers while facilitating collaboration with stakeholders and serving as a national hub of resources and best practices.

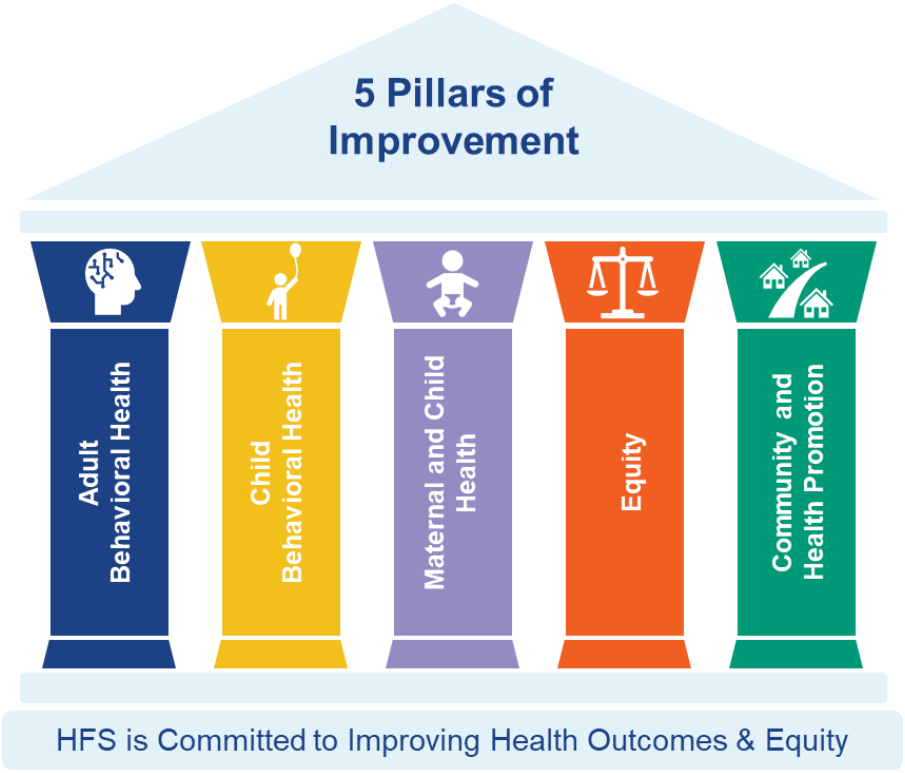
5

Quality Management

Comprehensive Medical Programs Quality Strategy

In FY 2024, HFS published the 2024-2027 Comprehensive Medical Programs Quality Strategy (Quality Strategy). Developed in accordance with federal regulations (42 CFR 438.340), 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. It puts a strong focus on using data-driven decision making to address health disparities, improve population health, transition to value-based payment models, and promote community-based care.

To support health equity and HFS' vision for improvement, HFS focused its Quality Strategy framework on 5 pillars of improvement: Adult Behavioral Health, Child Behavioral Health, Maternal and Child Health, Equity, and Improving Community and Health Promotion.



The Quality Strategy outlines specific goals, objectives, and quality measures to help drive progress across the 5 pillars of improvement.

HFS reviews and updates the Quality Strategy as needed, but no less than every 3 years. Reviews include evaluation of the effectiveness of the Quality Strategy using multiple data sources. Updates are made based on MCO performance, stakeholder input and feedback, achievement of goals, changes resulting from legislation or regulations, and/or significant changes to the Medicaid program.

Monitoring Managed Care Quality

Federal regulations (42 CFR 438) require states that contract with Medicaid MCOs to implement a comprehensive quality assessment and performance improvement program. In line with the Quality Strategy, HFS' program for monitoring managed care quality is done through systematic monitoring, evaluation, and collaboration with the MCOs.

External Quality Review

HFS contracts an external quality review organization (EQRO) to perform independent assessment of the quality, timeliness, and accessibility of the healthcare services provided by MCOs. The EQRO conducts external quality reviews to ensure that Medicaid customers receive appropriate and effective care. The key functions of the EQRO in Illinois include assessing MCO compliance with federal regulations and contractual requirements, validating performance measures, validating encounter data, reviewing provider network adequacy, conducting quality studies, and providing technical assistance.

Quality Assessment and Performance Improvement Program

Each MCO has a Quality Assessment and Performance Improvement (QAPI) program, designed to assess quality and identify areas where MCO processes and operations need adjusted to improve the quality of care provided to customers. The QAPI programs consist of a committee that must meet regularly, with a frequency sufficient to demonstrate the committee is following up on all findings and required actions. To ensure continuous quality improvement, MCOs conduct regular examination (annually at a minimum) of the scope and content of their QAPI program and submit a written report to HFS on their findings. The report includes an executive summary that provides a high-level discussion/analysis of each area of the annual report of findings, accomplishments, barriers, and continued need for quality improvement.

Quality Metrics and Performance Targets

MCOs submit results for a variety of performance measures to assess each health plan's individual and the program's collective performance. To focus efforts on driving progress in the 5 pillars of improvement, HFS selected a subset of these measures as program objectives and identified performance targets for each objective. Performance targets are also designated for other select measures, such as those in its pay-for-performance (P4P) and pay-for-reporting (P4R) programs, which direct focused efforts on initiatives. The totality of quality metrics collected and reported provide HFS with quantifiable information to evaluate successes and identify opportunities for improvement. A full list of quality measures collected for Illinois' Medicaid program can be found in HFS' published Quality Strategy.

P4P and P4R

The P4P and P4R programs are designed to improve quality by incentivizing spending on care that will increase quality of life outcomes. Under these initiatives, HFS selects a series of P4P and P4R measures, aligned with the 5 pillars of improvement, and sets performance targets for each. MCOs then have a percentage of their capitation rate withheld, which they can earn back by meeting or exceeding the established performance measure benchmarks.

Under the Medicare-Medicaid Alignment Initiative (MMAI) contracts, both Medicare and Medicaid also withhold a percentage of their respective components of the capitation rate. MMAI MCOs can earn back their withholds if the MCO meets or exceeds performance on a combination of core quality withhold measures across all demonstrations nationally as well as Illinois-specific quality withhold measures.

In FY 2024, HFS reported on conclusions of its EQRO's assessment of the 2021–2024 Quality Strategy. The evaluation found that on P4P measures, the statewide rate met the national benchmark on 4 measures and demonstrated relative improvement on 5 others. For P4R measures that were evaluated against national benchmarks, the statewide rate met or exceeded the 50th percentile when compared against national benchmarks for 5 of the 6 measures. For P4R measures that were evaluated against prior year performance only, the statewide rate demonstrated improvement for 9 of the 10 measures.

Consumer Report Cards

As part of its managed care program customer education and enrollment assistance process, HFS publishes an annual HealthChoice Illinois (HCI) Consumer Report Card (Report Card). The Report Card is a quality comparison tool that reflects the performance of the managed care program by comparing the MCOs across key performance areas which align with HFS' goals and pillar-focused population streams. The 6 performance areas included in the Report Cards are:

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

Each MCO is assigned up to 5 stars to indicate how it performs relative to other MCOs on each measure. The information used to create the Report Card is collected from the MCOs and their members and is reviewed for accuracy by HFS' contracted EQRO annually. The HCI Consumer Report Cards are found here: https://enrollhfs.illinois.gov/en/healthchoice-illinois

6

Service Delivery Systems

Medicaid Service Delivery Systems

The HFS medical assistance programs deliver healthcare to customers through 2 primary service delivery systems: fee-for-service (FFS) and managed care. Under the FFS system, HFS pays healthcare providers directly for each service provided to Medicaid customers. Under the managed care program, HFS contracts with MCOs, also commonly referred to as health plans, to operate the Medicaid benefit for eligible customers. This section of the report provides an overview of core programs, services, and initiatives within both FFS and managed care.

Illinois' Managed Care Program

In FY 2024, Illinois' statewide, integrated managed care program provided quality healthcare services and enhanced care coordination to upwards of 80% of all Medicaid customers. The managed care program aligns with HFS' mission and goals by advancing health equity, addressing social determinants of health, and promoting quality outcomes.

Key Components of Managed Care:

- **Care Coordination:** Care coordinators are assigned to help members, especially those with chronic conditions, identify care needs and navigate the healthcare system to meet those needs. To identify members with care coordination needs, the health plans assess risk for their enrolled population using predictive modeling and the completion of a health risk screening for all new enrollees.
- **Covered Benefits:** MCOs must offer their members the same comprehensive set of services available to the FFS population, unless specifically excluded. All MCOs offer extra benefits to their members, above and beyond what is available under the FFS system. A chart comparing these extra benefits offered can be found on the Illinois Client Enrollment Services website at: https://enrollhfs.illinois.gov/en.
- **Capitated Payments:** MCOs are paid a fixed monthly payment (known as capitation) for each enrolled member, regardless of how many services the member uses. The MCO in turn is responsible for coordinating care and for directly reimbursing their network of

MARIA'S STORY

Homeless and diagnosed with bipolar disorder, Maria called her MCO to report being pregnant. She had not been taking her medications and felt her current doctor wasn't helpful. With support from her MCO, Maria soon had stable housing, a maternity care package, food assistance, home visits through the Better Birth Outcome program, and transportation to a new doctor. Healthy little Owen was born last year, and Maria went to all her postpartum appointments. She finally has the resources and confidence to rebuild her social support system and pursue her goal to become a nurse.

providers who deliver care to their members. More information on managed care reimbursement is included later in this section.

- **Provider Networks**: Each MCO is required to have a robust, accessible network of healthcare providers from which their members receive care. These networks must consider factors such as provider types, specialist needs, geographic distribution, appointment wait times, and cultural and linguistic competency. Regular monitoring of MCO network adequacy is performed by the state's EQRO.
- **Quality Monitoring**: HFS is required to implement quality and performance improvement within managed care in line with its Comprehensive Medical Programs Quality Strategy. Key elements of MCO quality monitoring include reporting on quality measures and performance outcomes, conducting targeted performance improvement projects, the publishing of a health plan report card, and compliance monitoring in line with federal regulations.

Illinois Managed Care Programs

HFS operates 3 care coordination programs within the broader Illinois managed care program:

- **HealthChoice Illinois (HCI).** In FY 2024, HFS continued to contract with 5 HCI health plans who serve:
  - Families and children;
  - Affordable Care Act (ACA) adults;
  - Seniors and adults with disabilities who are not eligible for Medicare;
  - Dual Medicare-Medicaid eligible adults (dual eligibles) receiving certain long term services and supports (LTSS), referred to as the MLTSS population;
  - Special needs children, Former Youth in Care, and Youth in Care; and,
  - Adults and senior immigrants (as of 1/1/2024).

- **HealthChoice Illinois YouthCare (YouthCare).** YouthCare is the statewide, specialized MCO that provides services to the DCFS Youth in Care as well as DCFS Former Youth in Care. Youth in Care are youth for whom DCFS has legal responsibility and includes youth living with foster parents, in group homes, or in residential settings. Former Youth in Care are youth who were previously in the care of DCFS and includes youth who have been adopted, are living with kinship providers, have returned to biological parents, and/or have left the child welfare system. With YouthCare, DCFS youth receive additional benefits, such as trauma-informed care coordination for behavioral health needs and specialized programming for adoptive families. HFS partners closely with DCFS, YouthCare, and

various stakeholders to support program initiatives and workgroups to enhance the quality of care for DCFS youth.

- **Medicare-Medicaid Alignment Initiative (MMAI).** The MMAI 3-way partnership between HFS, CMS, and 5 MCOs delivers care to customers who are eligible for both Medicare and Medicaid services. These dually eligible customers enrolled in MMAI receive the full range of services covered under the Medicare and Medicaid programs, including LTSS services. Providers bill a single MCO, regardless of whether the service is covered under Medicare, Medicaid, or both. Enrollment in MMAI is voluntary; customers can opt in or out of the program at any time. On April 29, 2022, CMS issued a final rule for the Medicare Advantage (MA) and Part D programs, requiring states to convert all MMAIs to integrated dual eligible special needs plans (D-SNPs). During FY 2024, HFS continued to prepare for the transition to D-SNPs effective January 1, 2026.

ANTHONY'S STORY

Anthony was born with craniofacial abnormalities and has gone through various surgeries and requires a vigorous treatment plan due to his condition. Anthony's dad called their Care Coordinator to explain that while the cost of groceries has increased, their budget had not, and they were struggling to feed the family. Their Care Coordinator was able to quickly place an order for emergency meals to be delivered through the FoodCare Program. Within hours, Anthony's family received a call saying that their food was on the way.

MCO Program Enrollment Numbers

HealthChoice Illinois (HCI)	**Health Plan**	**June 2024 Enrollment**
Enrollees: Children and their parents, ACA adults, seniors and persons with disabilities, special needs children, Youth in Care, former Youth in Care, adults and senior immigrants, and dual eligible adults ages 21+ who receive LTSS and have opted out of MMAI.	Aetna Better Health of Illinois	367,804
	Blue Cross Community Health Plans	720,311
	CountyCare Health Plan (Cook County only)	428,958
	Meridian Health	758,542
	Molina Healthcare	307,479
	YouthCare	35,624
Geographic Service Area: Statewide		
Mandatory Enrollment: Yes	**Total HCI Enrollment**	**2,618,718**

Medicare-Medicaid Alignment Initiative (MMAI) **Enrollees**: Dual eligible adults ages 21+ who are eligible for both Medicare and Medicaid services and who have not opted out of MMAI. **Geographic Service Area**: Statewide **Mandatory Enrollment**: No	Health Plan	June 2024 Enrollment
	Aetna Better Health Inc.	14,727
	Blue Cross and Blue Shield of Illinois	20,649
	Humana Health Plan	14,609
	Meridian Complete Health Plan Inc.	14,941
	Molina Healthcare of Illinois	15,097
	Total MMAI Enrollment	**80,023**

Total Managed Care Programs Participation	Health Plan	June 2024 Enrollment
HCI, MMAI	Aetna Better Health Inc.	382,531
HCI, MMAI	Blue Cross and Blue Shield of Illinois	740,960
HCI	CountyCare Health Plan	428,958
MMAI	Humana Health Plan	14,609
HCI, MMAI	Meridian Complete Health Plan Inc.*	809,107
HCI, MMAI	Molina Healthcare of Illinois	322,576
	Total Managed Care Enrollment	**2,698,741**

*Meridian Complete Health Plan Inc. totals are inclusive of YouthCare

Managed Care Program Reimbursement

HCI Capitation Rates

MCOs are reimbursed through capitation rates which the federal government must approve. Capitation rates are a fixed amount of money, referred to as per member per month (PMPM) payments, which HFS pays monthly for the MCOs to assume full responsibility or risk for providing customers with healthcare services. The rates are developed based on encounter claims from the MCOs that are validated by HFS' consulting actuaries. Adjustments are made for healthcare management, trends, program changes, and MCO administration. All capitation rates must be actuarially sound per federal regulations (42 CFR 438.4(a)). Rates may be updated periodically to reflect future time periods, additional service packages, additional populations, or other actuarially significant changes.

MMAI Capitation Rates

Both CMS and HFS contribute to the global MMAI capitation payments. MMAI MCOs receive 3 monthly payments for each enrollee: 1 from CMS reflecting coverage of Medicare Parts A/B services, 1 from CMS reflecting coverage of Medicare Part D services, and 1 from HFS reflecting coverage of Medicaid services. The Medicare Parts A/B rate component and the Medicare Part D payment are risk adjusted using the prevailing CMS risk adjustment models,

while the Medicaid rate component is adjusted based on an enrollee's age, geographic service area, and care setting (nursing facility, HCBS waiver, or community). It includes an LTSS blended rate based on the nursing facility and HCBS waiver enrollment mix in each MCO at the beginning of the calendar year. The nursing facility portion of the blended LTSS rate is risk adjusted.

Directed and Pass-through Payments

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

P4P and P4R

In addition to capitation rates, the HCI contracts include P4P measures, selected to align with HFS' 5 quality pillars, to incentivize spending on care that will increase quality of life outcomes. P4P measures are ensured by withholding a percentage amount (withhold) from the MCO's capitation rate. The MCOs can earn back the withhold by meeting or exceeding the set performance measure benchmarks. Under the MMAI contracts, both Medicare and Medicaid also withhold a percentage of their respective components of the capitation rate. MMAI MCOs can earn back their withholds if the MCO meets or exceeds performance on a combination of core quality withhold measures across all demonstrations nationally as well as Illinois-specific quality withhold measures. More information on P4P and P4R can be found in the Comprehensive Medical Programs Quality Strategy.

Medical Loss Ratio

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

Overcoming the Change HealthCare Ransomware Attack

In February 2024, Change Healthcare, a subsidiary of UnitedHealth Group, experienced a significant ransomware attack. This breach compromised the personal, health, and financial information of approximately 100 million individuals, marking it as the largest healthcare data breach ever reported to federal regulators. The breach had widespread repercussions across the entire healthcare sector, including the Illinois medical assistance programs.

In response to the cyberattack, HFS took several measures to mitigate the impact on healthcare providers and ensure continued customer care. Recognizing the disruption caused by the system outage, HFS extended the operating hours of its pharmacy hotlines to assist providers with eligibility verification and to reinforce emergency service protocols. Specifically, the Prior Approval and Refill too Soon Hotline and the Pharmacy Billing Consultant Hotline were made available from 8:30 am to 5 pm on weekends during the outage.

More impactfully, HFS temporarily waived prior authorization requirements for certain practitioner-administered drugs within its FFS program. This decision was made to ensure that customer care remained uninterrupted during the system outage caused by the cyberattack. Practitioners were permitted to submit claims for these drugs without prior approval for dates of service affected by the outage, and such claims were not subject to post-approval processes. HFS emphasized the importance of continuing to provide timely access to high-quality care during this period.

Providers were advised to monitor daily notices for updates regarding the resolution of the system outage and the resumption of prior authorization requirements. HFS strongly encouraged providers to subscribe to email notifications to stay informed about any changes. These proactive steps by HFS aimed to support healthcare providers during the disruption and maintain essential services for patients across Illinois.

Long Term Care Program

HFS is responsible for the Medicaid Long Term Care (LTC) program, which annually serves approximately 55,000 eligible residents across more than 700 institutional facilities. There are 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).

Licensed and Medicaid Certified LTC Beds (FY 2024 Actual)

Level of Care	Medicaid Certified Beds[1]	Licensed Beds[2]
Skilled Care	69,089	76,884
SMHRFs	N/A	3,823
ICF	8,254	8,386
ICF/IID	3,893	3,893
Skilled Care for Individuals with Intellectual Disabilities	1,168	1,168
Total	**82,404**	**94,154**

1 Reflects beds that participate in the medical assistance program and are available to Medicaid residents.
2 Reflects beds 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.

Certification/Decertification of LTC Facilities

During FY 2024, 9 NFs closed. Of those, 8 closed due to financial hardship while the other 1 closed due to flooding/building damage. One NF enrolled in the medical assistance program during this same period.

LTC Provider Assessment

The LTC provider assessment 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 those facilities. These funds have helped HFS provide critical institutional services to some of the neediest and most frail Illinoisans. On July 1, 2022, the LTC assessment program was restructured to terminate a $1.50 assessment on licensed beds days and to revise the assessment on non-Medicare occupied bed days from a uniform tax of $6.07 to a varied tax based on the provider's volume of Medicaid days. This change nearly doubled the assessment collections as well as the federal revenues in its first year and has continued to increase in FY 2024.

Funds Generated by the LTC Provider Assessment

Fiscal Year	Nursing Facilities	ICF/IIDs
2021	$162.6 M	$20.2 M
2022	$160.6 M	$20.7 M
2023	$302.2 M	$20.8 M
2024	$327.9 M	$21.5 M

Nursing Facility Reimbursement

NFs are paid at a per diem rate, which has 3 separate components: nursing, capital, and support. The capital and support components of the rate are developed based on cost reports NFs submit to HFS while the nursing component is based on the NF's case mix (average resident needs and service provided to each resident within the NF).

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 1 NF. Additionally, capital exceptions resulted in rate changes for 63 facilities in FY 2024.

1915(c) HCBS Waivers

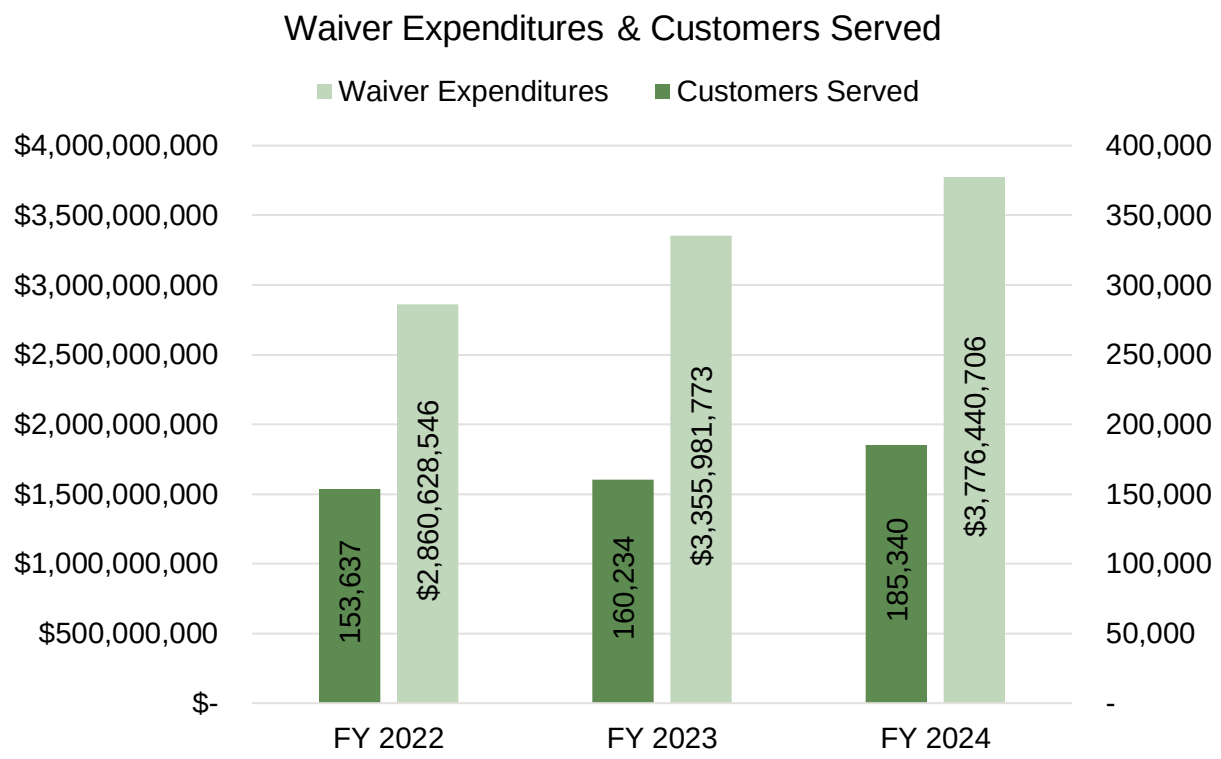
A Medicaid 1915(c) HCBS waiver allows states to provide long term services and supports in community settings rather than institutional facilities, such as nursing homes. These waivers promote independence, community integration, and cost savings by reducing reliance on institutional care. Each year, every waiver program must demonstrate the cost of services for participants is not more than the cost of serving the same population in an institution.

Illinois' 9 1915(c) HCBS waivers served a total of 185,340 customers in FY 2024.

HFS partners with the Department on Aging (DOA), the DHS Divisions of Rehabilitative Services (DRS) and Developmental Disabilities (DDD), and the University of Illinois Chicago's Division of Specialized Care for Children (UIC-DSCC) to operate the state's 9 1915(c) HCBS waivers. These operating agencies specialize in the specific population or services targeted by the waiver and are responsible for managing day-to-day operations. HFS, in its role as the single state Medicaid authority, provides administrative coordination, direction, oversight, program, fiscal, and quality monitoring for all 9 waivers.

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

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



Electronic Visit Verification

In FY 2024, Illinois ushered in the federally mandated Electronic Visit Verification (EVV) system, a technology-based solution designed to verify home health care visits by capturing essential details such as time, location, and attendance of home care workers. EVV is required for personal care services and home health care. This system aims to enhance program integrity, reduce errors, and ensure that customers received authorized services.

In spring 2022, Illinois selected HHAeXchange as Illinois' EVV vendor. Following this decision, HFS worked with stakeholders, sister state agencies, MCOs, providers, and customers to ensure the implementation of the EVV system was practical and efficient. HFS continues to be committed to working with customers, providers, and vendors to meet training needs and quickly implement quality solutions.

On September 1, 2023, EVV requirements were implemented for personal care services under the 1915(c) HCBS waivers administered by DHS-DDD. By the end of December 2023, EVV was implemented for all home health care services provided to Medicaid customers. HHAeXchange has established a dedicated help line to support Illinois providers with EVV requirements, which can be reached at 833-961-7429.

HFS and its partners continue to collaborate and plan for the ongoing implementation of EVV for all services and provider types to ensure compliance with federal regulations.

Money Follows the Person

The Money Follows the Person (MFP) Demonstration is a federally funded grant program designed to support states in rebalancing long term care systems towards community-based care. The key goal of MFP is to help Medicaid customers transition from institutional care back into community-based settings by improving access to HCBS, reducing the Medicaid system's overall reliance on institutional care. MFP was originally authorized in 2005 by the Deficit Reduction Act (DRA) and has received a series of extensions since then to continue program funding.

In fall 2022, Illinois was 1 of 5 states awarded a $5 million MFP Planning Phase grant. The purpose of the Planning Phase is to: (1) assess for gaps in current community-based long term services, supports, and resources; (2) expand and positively impact recruitment and retention of direct care workers and the full range of needed home-based providers; and (3) design an Operational Protocol to define the MFP Implementation Phase.

In FY 2024, HFS had its grant funding renewed through September 2026. A dedicated Project Manager and Data/Quality Analyst Manager were hired to oversee the work of MFP. Additionally, HFS engaged UIC to design and conduct a statewide HCBS gap analysis, targeted for completion in FY 2025. Planning Phase activities also continued in collaboration with the DHS, DOA, the Illinois Housing Development Authority (IHDA), advocates, potential program participants, and other interested parties.

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 MCOs

Please note: The payment and utilization data presented in this section and the outpatient section that follows includes those customers covered under the FFS program and by an MCO. These sections do not include data from the large government-owned or university-owned hospitals that provide a portion of the state's share of reimbursement, nor does it include hospital payments that are partially funded through hospital assessments, unless otherwise noted.

Inpatient Hospital Services - General Revenue Fund

Inpatient hospital claims consist of acuity-based groupings, called All Patient Refined Diagnosis Related Groups (APR-DRG) with several specialized claims-based add-ons, including disproportionate share, safety-net, psychiatric, Medicaid Percentage Adjustment and Medicaid

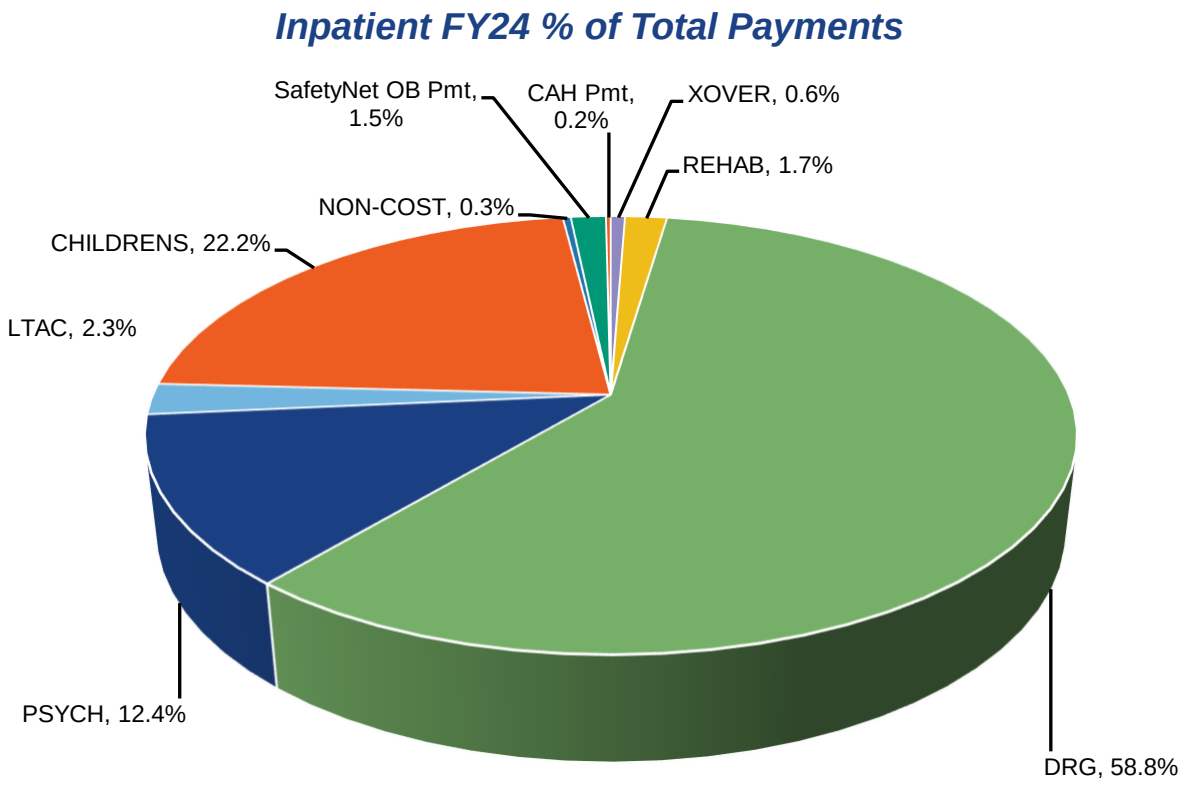
High Volume Adjustment. Some types of claims are excluded from the APR-DRG and continue to be paid on a per diem basis, including psychiatric and rehabilitation hospital claims and services provided by long term acute care (LTAC) hospitals and non-cost reporting hospitals.

FY 2024 hospital inpatient liability, including payments for both FFS and MCO claims, totaled $3.4 billion, up 8% from the $3.2 billion spent in FY 2023. Inpatient admissions saw an 11% decrease in FY 2024.

To advance the goal of improving child and maternal health outcomes, HFS paid $50 million through general revenue fund (GRF) funded supplemental payments to safety net hospitals that provide inpatient obstetric services with an emphasis on those that provided over 1,000 deliveries annually and $10 million to Critical Access Hospitals with an emphasis on those that have a perinatal designation from the Department of Public Health (DPH).

As shown in the following graph, 59% of the $3.4 billion in FY 2024 hospital inpatient payments were made pursuant to the APR-DRG based system; this percent is unchanged from FY 2023.

FY 2024 GRF Hospital Inpatient Spending - $3.4 billion



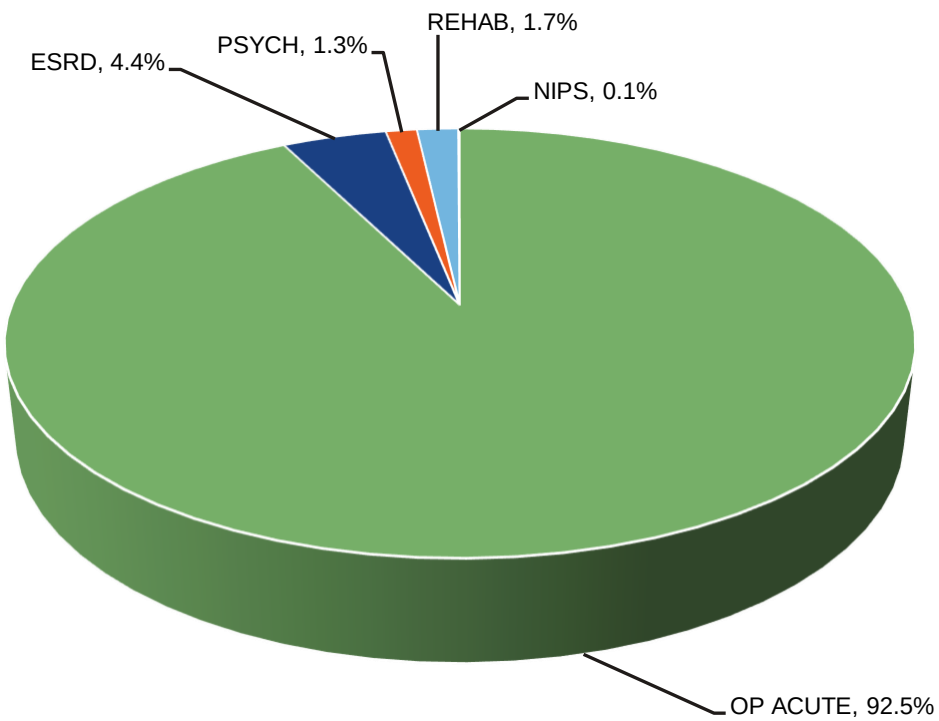
Ambulatory Care Services

The Enhanced Ambulatory Patient Grouping (EAPG) reimbursement system works much like the inpatient DRG system, assigning like procedure codes to an EAPG group and assigning relative weights to the groups based on national averages of resource consumption to provide the services. This system allows hospitals to be paid for multiple procedures on 1 claim and incorporates discounting and consolidation of payments when appropriate.

Total spending on outpatient claims paid via the EAPG system increased 10% to $2.5 billion in FY 2024, compared to the $2.3 billion in FY 2023. FY 2024 also saw a 2% decrease in the number of outpatient services provided, from 9 million services in FY 2023 to 8.8 million in FY 2024.

FY 2024 GRF Hospital Outpatient Spending - $2.5 billion

Outpatient FY24 % of Total Payments



Disproportionate Share Hospitals

Federal law requires hospitals that serve a disproportionate number of low-income patients with special needs be given an appropriate increase in their inpatient rate or payment amount. Additionally, states are federally mandated to provide the increased payment to any hospital whose Medicaid inpatient utilization rate is at least 1 standard deviation above the mean

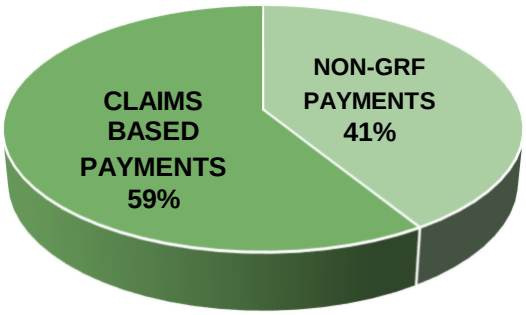
Medicaid inpatient utilization rate or whose low-income utilization rate exceeds 25%. In FY 2024, HFS expended $286.2 million of its federal Disproportionate Share Hospital (DSH) allotment, which equated to about $552.7 million in total spending, including state matching funds.

The following number of hospitals qualified for DSH in rate year 2024: 56 private (non-governmental) hospitals, including 17 which received DSH payments because they were within the federal guidelines set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1993; 2 state-operated psychiatric hospitals qualified for DSH because their low-income utilization rate exceeded 25%; and government-owned hospitals (University of Illinois Hospital and Cook County Hospitals and Health Systems). As federally required, HFS performs an annual OBRA calculation to ensure spending to each hospital does not exceed the combined costs of services to the Medicaid and uninsured populations.

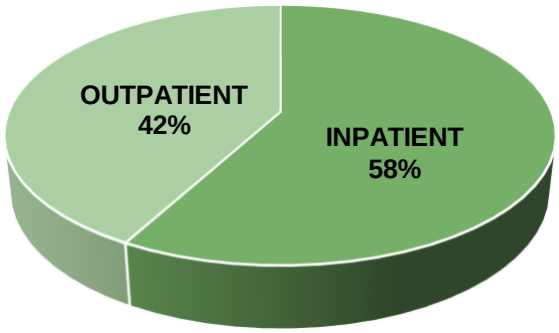
Non-GRF Funded Hospital Payments

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 $4.1 billion in payments were made to the hospitals in FY 2024 through supplemental payments and graduate medical education (GME) payments made directly to the hospitals and through MCOs in the form of directed payments and pass-through payments.

Total FY 2024 Hospital NON-GRF Payments vs Claims



Total FY 2024 Hospital Payments Inpatient vs Outpatient



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Appendices

APPENDIX I – AGENCY CONTACT INFORMATION

Agency Website: https://hfs.illinois.gov/

Phone: 217-782-1200

Email: HFS.Webmaster@illinois.gov

Customer Hotline Numbers

If you or someone you know is experiencing a behavioral health crisis or you have concerns for their immediate safety, please call 988 to talk with a 988 Suicide & Crisis Lifeline counselor. Services are available 24/7, 365 days a year.

All Kids Hotline	1-866-255-5437 / 1-877-204-1012 (TTY)
All Kids Credit Card Payment Hotline	1-877-828-2375
Crisis Referral and Entry Service (CARES) *Behavioral Health Crisis Dispatch Hotline*	1-800-345-9049 / 773-523-4504 (TTY)
Eligibility Inquiry Hotline	1-855-828-4995
Illinois Client Enrollment Broker	1-877-912-8880 / 1-866-565-8576 (TTY)
Illinois Health Benefits Hotline	1-800-226-0768

Healthcare Provider Hotline Numbers

Drug Prior Approval/Refill-Too-Soon	1-800-252-8942
Eligibility Inquiry Hotline	1-800-842-1461
IMPACT Provider Enrollment	1-877-782-5565
Medicaid Technical Assistance Center (MTAC)	217-244-3212
Prior Approvals	1-800-642-7588
Provider Billing Hotline	1-877-782-5565

APPENDIX II – HEALTHCARE PROGRAMS

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

1619A and 1619B

Description – 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[1] – No **Benefit Type** – Comprehensive **Cost Sharing**[2] – No

ACA Adults

Description – Adults ages 19-64 without minor children in the home who do not receive Medicare and have income up to 138% FPL. In 2024, this translates to $1,732 per month for an individual or $2,351 for a couple.
Presumptive Eligibility – Yes **Benefit Type** – Comprehensive **Cost Sharing** – No

Aid to Aged, Blind, and Disabled (AABD)

Description – Persons who are ages 65 and older, who are blind or disabled, with monthly income up to 100% FPL (in 2024, $1,255 for a single person or $1,703 for a couple) and no more than $17,500 of non-exempt resources.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – No

All Kids Assist

Description – Children up to age 19 with family income at or below 318% FPL. In 2024, this translates to $8,268 per month for a family of 4.
Presumptive Eligibility – Yes **Benefit Type** – Comprehensive **Cost Sharing** – No

DCFS Youth

Description – Children in DCFS custody as well as children placed in subsidized guardianship and adoption assistance arrangements. No income or resource limitations.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – No

Emergency Medical for Non-Citizens

Description – Individuals who are not U.S. citizens or do not have a legal immigration status that qualifies them for Medicaid under federal law and who meet all other nonfinancial and financial criteria for the FamilyCare Assist, AABD, or the ACA adult healthcare program. A Social Security Number is not needed.
Presumptive Eligibility – No **Benefit Type** – Partial **Cost Sharing** – No

FamilyCare Assist

Description – Parents and caretaker relatives raising dependent minor children with an income at or below 138% FPL. In 2024, this translates to $3,588 per month for a family of 4.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – Yes

Family Planning

Description – Illinois residents of any age or gender who are U.S. citizens or qualified immigrants with income up to 213% FPL and who are not enrolled in Medicaid. The applying individual is counted in a household of their own (i.e., given a household size of 2).
Presumptive Eligibility – Yes **Benefit Type** – Partial **Cost Sharing** – No

Former Foster Care

Description – Former DCFS Youth in Care ages 19-25 who were enrolled in Medicaid when they aged out of foster care. No income or resource limitations.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – No

Health Benefits for Asylum Applicants and Torture Victims

Description – 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 the AABD program.

Presumptive Eligibility – No **Benefit Type** – Comprehensive for limited time **Cost Sharing** – No

Health Benefits for Immigrant Adults (HBIA) (new enrollments paused)

Description – Illinois residents ages 42 through 64 whose immigration status does not meet the requirements for coverage under another eligibility group.

Presumptive Eligibility – No **Benefit Type** – Partial **Cost Sharing** – Yes

Health Benefits for Immigrant Seniors (HBIS) (new enrollments paused)

Description – Illinois residents ages 65 and older whose immigration status does not meet the requirements for coverage under another eligibility group. Eligibility criteria is otherwise similar to AABD.

Presumptive Eligibility – No **Benefit Type** – Partial **Cost Sharing** – Yes

Health Benefits for Persons with Breast or Cervical Cancer

Description – Individuals under age 65 without insurance that covers cancer treatment and whose breast or cervical cancer diagnosis has been confirmed by DPH. There is no income limit or resource test.

Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – No

Health Benefits for Workers with Disabilities (HBWD)

Description – Employed persons, ages 16-64, with disabilities and earnings up to 350% FPL (in 2024, $4,393 per month for an individual, $5,962 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 Type** – Comprehensive **Cost Sharing** – Yes

Moms and Babies

Description – Pregnant women and their babies up to age 1 with family income at or below 213% FPL. In 2024, this translates to $5,538 a month for a family of 4, inclusive of the unborn baby. Babies under 1 are eligible at any income level if Medicaid covered their mother at the time of birth.

Presumptive Eligibility – Yes **Benefit Type** – Comprehensive **Cost Sharing** – No

Medicare Savings Program (MSP)

Description – There are 3 programs for individuals eligible for Medicare Part A: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIB), and Qualified Individual (QI-1). Income limits vary per program; however, income is less than or equal to 135% FPL plus $25 (monthly SSI income disregard). Resource limits are $9,430 for a single person and $14,130 for a couple.

Presumptive Eligibility – No **Benefit Type** – Limited to coverage of Medicare cost sharing expenses

Cost Sharing – N/A

Veterans Care (new enrollment closed effective March 2016)

Description – Uninsured veterans ages 19-64 who were not dishonorably discharged from the military, served 180 days in the military after initial training, are income eligible, and who are not eligible for healthcare from the U.S. Department of Veterans Affairs or medical assistance under the Illinois Public Aid Code.

Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – Yes

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

State Chronic Renal Disease Program

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

State Hemophilia Program

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

State Sexual Assault Survivors Emergency Treatment Program

Description – Survivors of sexual assault who are not eligible under another program.
Presumptive Eligibility – No **Benefit Type** – Partial **Cost Sharing** – No

APPENDIX III – MANDATORY & OPTIONAL SERVICES

Federally Mandated Services in FY 2024

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

- Certified pediatric and family nurse practitioner services
- Emergency service for non-citizens
- EPSDT: Early and periodic screening, diagnostic, and treatment services for individuals under age 21
- Family planning services and supplies
- Federally qualified health center services
- Freestanding birth center services
- Home health services
- Inpatient hospital services
- Laboratory and x-ray services
- Medical/surgical services by dentist
- Medication assisted treatment (MAT)
- Nurse midwife services
- Nursing facility services (ages 21 and over)
- Outpatient hospital services
- Physician medical and surgical services
- Routine patient costs of items and services for beneficiaries enrolled in qualifying clinical trials
- Rural health clinic services
- Tobacco cessation counseling for pregnant women
- Transportation to covered medical services

Optional Services Provided in FY 2024

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:

- Acupuncture services, limited to procedures related to lower back pain and breech baby treatment
- All approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration without cost-sharing
- Case management services
- Certified Registered Nurse Anesthetist
- Chiropractic services
- Clinic services
- Clinical Nurse Specialist
- Dental services, including dentures
- Diagnostic, screening, and preventive services, including diabetes programs, adaptive behavior support (ABS) services, doula services, lactation support services, and home visiting 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 ages 65 and older in institutions for mental diseases
- Intermediate care facility services for individuals with intellectual disabilities, including state-operated facilities
- Licensed Clinical Professional Counselor services
- Licensed Clinical Social Worker services
- Licensed Genetic Counselor services
- Licensed Certified Professional Midwife services
- Licensed Marriage and Family Therapist services
- Licensed Clinical Psychologist services
- Nursing facility services for individuals under 21 years of age
- Occupational therapy services
- Optometry services
- Pharmacist services, limited to specific birth control and HIV services
- Physical therapy services
- Podiatric services
- Prescribed drugs
- Prosthetic devices
- Rehabilitative services (Medicaid Rehab Option)
- School-based health
- Speech, hearing, and language disorder services
- State plan HCBS through a 1915(i)
- TB related services
- Transplant services

APPENDIX IV – EXPENDITURES AGAINST APPROPRIATIONS

THE DEPARTMENT MEDICAL ASSISTANCE PROGRAM Expenditures Against Appropriations FY 2022 – 2024 *Dollars in Thousands*						
	FY 2022 Expenditures	**Percent**	**FY 2023 Expenditures**	**Percent**	**FY 2024 Expenditures**	**Percent**
Total [1,2]	**$22,150,629.1**	**100.0%**	**$25,376,570.8**	**100.0%**	**$25,705,421.7**	**100.0%**
Hospitals	**1,020,345.8**	**4.6%**	**1,131,598.0**	**4.5%**	**1,211,469.9**	**4.7%**
Long Term Care [3]	**409,509.7**	**1.8%**	**562,791.7**	**2.2%**	**640,324.9**	**2.5%**
Practitioners	**228,287.3**	**1.0%**	**282,924.0**	**1.1%**	**329,497.4**	**1.3%**
Physicians	186,733.3	0.8%	233,843.4	0.9%	275,075.9	1.1%
Dentists	36,706.8	0.2%	43,511.4	0.2%	49,272.0	0.2%
Optometrists	3,548.8	0.0%	3,942.2	0.0%	3,472.2	0.0%
Podiatrists	1,286.6	0.0%	1,614.3	0.0%	1,645.6	0.0%
Chiropractors	11.8	0.0%	12.7	0.0%	31.7	0.0%
Drug	**911,038.7**	**4.1%**	**1,096,917.5**	**4.3%**	**1,223,178.6**	**4.8%**
Other Medical	**2,397,729.0**	**10.8%**	**2,292,681.2**	**9.0%**	**1,540,457.8**	**6.0%**
Laboratories	79,301.6	0.4%	79,779.0	0.3%	41,132.7	0.2%
Transportation	562,832.9	2.5%	682,643.4	2.7%	651,987.0	2.5%
SMIB/HIB/Expansion	753,836.6	3.4%	779,280.9	3.1%	0.0	0.0%
Home Health Care/DSCC	192,356.8	0.9%	203,670.7	0.8%	216,644.4	0.8%
Appliances	28,475.1	0.1%	34,037.9	0.1%	28,716.5	0.1%
Other Related [5]	569,596.1	2.6%	294,746.1	1.2%	371,738.9	1.4%
Community Health Centers	62,391.4	0.3%	55,249.8	0.2%	61,526.8	0.2%
Medically Complex Development (MCDD)	116,052.5	0.5%	118,317.3	0.5%	118,485.5	0.5%
Hospice Care	32,886.0	0.1%	44,956.1	0.2%	50,226.0	0.2%
MCOs	**17,183,718.6**	**77.6%**	**20,009,658.4**	**78.9%**	**20,760,493.1**	**80.8%**
Children's Health Rebate	**0.0**	**0.0%**	**0.0**	**0.0%**	**0.0**	**0.0%**

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

2 Includes funds from the Provider Assessment Program, IMDs and SLFs.

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

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

Table Prepared By: Division of Finance

Data Source: Division of Finance, Comptroller Spending Report FY 2024.

APPENDIX V – MEDICAL ASSISTANCE PROGRAM BOARDS AND COMMISSIONS

The HFS Boards and Commissions listed oversee and advise Illinois' elected officials, state agencies, and organizations on a wide range of issues that affect the medical assistance program. These boards and commissions also play a vital role in promoting efficient, effective, and honest government. More information, including members and meeting information, can be found on the HFS website at: https://hfs.illinois.gov/about/boardsandcommisions.html

- Advisory Council on Financing and Access to Sickle Cell Disease Treatment and Other High-Cost Drugs and Treatment
- Child Welfare Medicaid Managed Care Implementation Workgroup
- Dental Policy Review Committee
- Drug Utilization Review Board (DUR Board)
- Illinois Drugs and Therapeutics Advisory Board
- Medicaid Advisory Committee (MAC)
    - Community Integration Subcommittee
    - Health Equity and Quality Subcommittee
    - Public Education Subcommittee
    - N.B. Stakeholder Subcommittee
- Medicaid Managed Care Oversight Commission

APPENDIX VI – ANNUAL REPORT STATUTORY REQUIREMENTS

HFS issues this Annual Report under 3 statutory requirements:

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

- Actual statistics and trends in utilization of medical services by Public Aid customers;
- Actual statistics and trends in the provision of the various medical services by medical vendors;
- Current rate structures and the proposed changes in those rate structures for the various medical vendors; and
- Efforts at utilization review and control by the Department.

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

- The rate structure used by the Department to reimburse nursing facilities;
- Changes to the rate structure for reimbursing nursing facilities;
- The administrative and program costs of reimbursing nursing facilities;
- The availability of beds in nursing facilities for Medicaid customers; and
- The number of closings of nursing facilities and the reasons for those closings.

Disabilities Services Act of 2003 (20 ILCS 2407/55) requires HFS to report annually on MFP, 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.