Illinois CARTS FY2020 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Illinois

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

All Kids Share, All Kids Premium 1 and All Kids Premium 2

Who should we contact if we have any questions about your report?

4. Contact name:

George Jacaway

5. Job title:

Chief, Bureau of All Kids

6. Email:

george.jacaway@illinois.gov

7. Full mailing address:

Include city, state, and zip code.

Illinois Dept of Healthcare and Family Services 201 South Grand Avenue East Springfield, IL 62763-0001

8. Phone number:

2175247318

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Medicaid expansion children receive health benefits coverage through managed care beginning for a month after the month in which eligibility is determined. All prior months of coverage, including retroactive months before the month in which eligibility is determined are fee for service months.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

◉ Yes

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

◉ Yes

○ No

2b. Indicate the range of premiums and corresponding FPL ranges for one child.

Premiums for one child, tiered by FPL

FPL starts at		FPL ends at
158	→	209

Premium starts at		Premium ends at
$ 15	→	$ 40

FPL starts at		FPL ends at
210	→	318

Premium starts at		Premium ends at
$ 40	→	$ 80

○ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

◉ Yes

3a. Indicate the range of premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at		FPL ends at
158	→	209

Premium starts at		Premium ends at
$ 180	→	$ 480

FPL starts at		FPL ends at
210	→	318

Premium starts at		Premium ends at
$ 480	→	$ 960

○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

No. Beginning in March 2020, Illinois suspended premiums for the extent of the COVID Public Health Emergency (PHE).

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [ ] Primary Care Case Management
- [x] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Initially, all children are FFS. They are given a period of 60 days to choose an MCO. They are auto assigned to an MCO if one is not chosen. Children in our Premium Level 2 program (income from 210-318% FPL) are currently all Fee for Service.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

- (●) Yes
- ( ) No
- ( ) N/A

2. Have you made any changes to the eligibility redetermination process?

- (●) Yes
- ( ) No
- ( ) N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ( ) Yes
- (●) No
- ( ) N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

The following changes were in response to the COVID PHE: Eligibility • Medicaid and CHIP Disaster SPAs: * Disregarded assets for AABD eligibility determinations; * Implemented presumptive eligibility for FamilyCare and ACA Adults; * Waived cost-sharing, including premiums for HBWD and both premiums and copays for All Kids Share and Premium programs and for Veterans Care; * Certification periods extended for RRP; * Increased frequency allowed for presumptive eligibility for pregnant women and children; * Delayed redeterminations of medical coverage in CHIP (Medicaid approved through concurrence); * Stopped closures of medical coverage and transitions to other programs in CHIP (Medicaid approved through concurrence) except for individuals who move out of state, request cancellation or die; and * Exception to timeliness standards for processing Medicaid applications in CHIP (Medicaid approved through concurrence). • CMS Concurrences: * Allows self-attestation of income, incurred medical expenses, residency, disability status, and insured status when electronic verification is not available; * Allows exception to timeliness standards for processing Medicaid applications; * Allows exception to timeliness standards for processing Medicaid renewals; * Suspends periodic data checks from electronic sources and suspend action on changes in circumstances; * Permits phone applications without recording of client authorization (telephonic signature); and * Increased the reasonable compatibility threshold to 30% for medical determinations (verification plan). Covered Services • COVID-19 Disaster SPA: * Cover COVID-19 testing and testing related services for new uninsured testing category (also noted above under eligibility); and * Added virtual check-ins and e-visits to the fee schedule. ♣ Allow FQHCs, RHCs, encounter rate clinics, and critical clinic providers to bill these codes FFS (outside of their encounter rate). • Appendix K: * Allow HCBS telehealth visits and virtual day service. Policy Changes • 1135 Waiver: * Suspend some prior authorization requirements in fee-for-service and managed care; * Extend pre-existing prior authorizations; * Allow telephonic and post admission screenings (within 10 days of admission) for the pre-admission screening and annual resident review (PASRR) assessment; ♣ Through state policy change, this same flexibility was also applied to the determination of need (DON) assessment and the Specialized SLP Mental Health assessment; * Allow provider licensing and enrollment flexibilities; and * Allow provision of services in alternate settings for NFs and ICF/DDs. ♣ This same flexibility was applied to additional provider types through blanket waiver authority, as noted below. • Implemented

CMS blanket waiver flexibilities, such as: * Physical signature requirement flexibilities; * Reimbursement for facility services provided in alternate settings; * Allow Medicaid payment for someone who has to be moved to a Medicare only certified bed or private pay bed; * Increased flexibilities for telehealth services, including non-HIPAA compliant modes; * EMTALA transfer flexibility; * Critical Access Hospital bed and length of stay flexibilities; * Long-term care nurse aid training and certification flexibilities; * Health and hospice supervision flexibilities for registered nurses; * Rural Health Centers and FHQC waivers of certain staffing and physician supervisory requirements for nurse practitioners; * Waive DME face-to-face requirements for replacement DME; * Modify deadlines for CMS Outcome and Assessment Information Set (OASIS) and Minimum Data Set (MDS) assessments and transmission; and * For medical records, allow verbal orders to be used more than infrequently and allow medical records to be fully completed more than 30 days after discharge. • CMS Concurrences: * Allow enrollment into MCOs without the initial 30-day choice period; all MCO members still have a 90-day switch period to change MCOs; and ♣ Will also be formalized in MCO COVID-19 contract amendment and an updated Disaster SPA. * Allow HFS and DHS additional time to take final administrative action on SFH requests as long as hearings requiring expedited action are prioritized. • Appendix K: * Allow HCBS services to be provided in different settings; * Allow HCBS telehealth visits and virtual day service; * Allow retainer payments; * Provide cost increases for to support additional costs due to the public health emergency; * Allow additional respite hours; * Modified homecare aid provider qualifications; * Increased community day service and at-home day service rates to support increased costs; * Allow telephonic outreach for some Adult Protective service outreach; * Allow remote monitoring of patient record reviews; and * Allow extensions for evidentiary packages and performance metrics. • COVID-19 Disaster SPA: * Allow Preferred Drug List (PDL) exemptions if prescription drug shortages occur; * Expands prior authorization for prescription drugs by automatic renewals without clinical review or time/quantity extensions; and * Increased rates to ICF/DD & MC/DD facilities by 20% from March 17 - August 31, 2020 to provide resources for additional staff and services to support residents while day service providers were required to be closed. • COVID-19 MCO Contract Amendment: * Require Managed Care Organizations (MCOs) to cover COVID-19 diagnoses and treatment by non-network providers; * Modified the MCO CY 2020 pay-for-performance (P4P) framework to reinvest in strategies that mitigate the impact of the COVID-19; * Added an MCO contract risk corridor mechanism to address the impact of

COVID-19 on the utilization of covered services, and * Allow initial MCO enrollment through direct auto-assignment. • Other Changes * Allow additional prescription drugs on the FFS 90-day supply list; * Incorporate COVID-19 symptom review into mobile crisis response processes; * Allow designated application assisters to assist with Medicaid and CHIP applications over the phone with additional representative form; * Relaxed 180-day timely filing limit; and * Temporarily suspend ORP edits (initially 1135 waiver request). (MD, LP, LT) See HFS COVID page: https://www.illinois.gov/hfs/Pages/coronavirus.aspx for SPAs, Appendix K, 1135 request, etc. See https://www.ilga.gov/legislation/publicacts/101/PDF/101-0649.pdf for the Medicaid omnibus with the COVID eligibility changes.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No
- ( ) N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

- (●) Yes
- ( ) No
- ( ) N/A

2. Have you made any changes to the eligibility redetermination process?

- (●) Yes
- ( ) No
- ( ) N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ( ) Yes
- (●) No
- ( ) N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ◉ Yes
- ○ No
- ○ N/A

16. Have you made any changes to your Pregnant Women State Plan expansion?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

The following changes were in response to the COVID PHE: Eligibility • Medicaid and CHIP Disaster SPAs: * Disregarded assets for AABD eligibility determinations; * Implemented presumptive eligibility for FamilyCare and ACA Adults; * Waived cost-sharing, including premiums for HBWD and both premiums and copays for All Kids Share and Premium programs and for Veterans Care; * Certification periods extended for RRP; * Increased frequency allowed for presumptive eligibility for pregnant women and children; * Delayed redeterminations of medical coverage in CHIP (Medicaid approved through concurrence); * Stopped closures of medical coverage and transitions to other programs in CHIP (Medicaid approved through concurrence) except for individuals who move out of state, request cancellation or die; and * Exception to timeliness standards for processing Medicaid applications in CHIP (Medicaid approved through concurrence). • CMS Concurrences: * Allows self-attestation of income, incurred medical expenses, residency, disability status, and insured status when electronic verification is not available; * Allows exception to timeliness standards for processing Medicaid applications; * Allows exception to timeliness standards for processing Medicaid renewals; * Suspends periodic data checks from electronic sources and suspend action on changes in circumstances; * Permits phone applications without recording of client authorization (telephonic signature); and * Increased the reasonable compatibility threshold to 30% for medical determinations (verification plan). Covered Services • COVID-19 Disaster SPA: * Cover COVID-19 testing and testing related services for new uninsured testing category (also noted above under eligibility); and * Added virtual check-ins and e-visits to the fee schedule. ♣ Allow FQHCs, RHCs, encounter rate clinics, and critical clinic providers to bill these codes FFS (outside of their encounter rate). • Appendix K: * Allow HCBS telehealth visits and virtual day service. Policy Changes • 1135 Waiver: * Suspend some prior authorization requirements in fee-for-service and managed care; * Extend pre-existing prior authorizations; * Allow telephonic and post admission screenings (within 10 days of admission) for the pre-admission screening and annual resident review (PASRR) assessment; ♣ Through state policy change, this same flexibility was also applied to the determination of need (DON) assessment and the Specialized SLP Mental Health assessment; * Allow provider licensing and enrollment flexibilities; and * Allow provision of services in alternate settings for NFs and ICF/DDs. ♣ This same flexibility was applied to additional provider types through blanket waiver authority, as noted below. • Implemented CMS blanket waiver flexibilities, such as: * Physical signature requirement

flexibilities; * Reimbursement for facility services provided in alternate settings; * Allow Medicaid payment for someone who has to be moved to a Medicare only certified bed or private pay bed; * Increased flexibilities for telehealth services, including non-HIPAA compliant modes; * EMTALA transfer flexibility; * Critical Access Hospital bed and length of stay flexibilities; * Long-term care nurse aid training and certification flexibilities; * Health and hospice supervision flexibilities for registered nurses; * Rural Health Centers and FHQC waivers of certain staffing and physician supervisory requirements for nurse practitioners; * Waive DME face-to-face requirements for replacement DME; * Modify deadlines for CMS Outcome and Assessment Information Set (OASIS) and Minimum Data Set (MDS) assessments and transmission; and * For medical records, allow verbal orders to be used more than infrequently and allow medical records to be fully completed more than 30 days after discharge. • CMS Concurrences: * Allow enrollment into MCOs without the initial 30-day choice period; all MCO members still have a 90-day switch period to change MCOs; and ♣ Will also be formalized in MCO COVID-19 contract amendment and an updated Disaster SPA. * Allow HFS and DHS additional time to take final administrative action on SFH requests as long as hearings requiring expedited action are prioritized. • Appendix K: * Allow HCBS services to be provided in different settings; * Allow HCBS telehealth visits and virtual day service; * Allow retainer payments; * Provide cost increases for to support additional costs due to the public health emergency; * Allow additional respite hours; * Modified homecare aid provider qualifications; * Increased community day service and at-home day service rates to support increased costs; * Allow telephonic outreach for some Adult Protective service outreach; * Allow remote monitoring of patient record reviews; and * Allow extensions for evidentiary packages and performance metrics. • COVID-19 Disaster SPA: * Allow Preferred Drug List (PDL) exemptions if prescription drug shortages occur; * Expands prior authorization for prescription drugs by automatic renewals without clinical review or time/quantity extensions; and * Increased rates to ICF/DD & MC/DD facilities by 20% from March 17 - August 31, 2020 to provide resources for additional staff and services to support residents while day service providers were required to be closed. • COVID-19 MCO Contract Amendment: * Require Managed Care Organizations (MCOs) to cover COVID-19 diagnoses and treatment by non-network providers; * Modified the MCO CY 2020 pay-for-performance (P4P) framework to reinvest in strategies that mitigate the impact of the COVID-19; * Added an MCO contract risk corridor mechanism to address the impact of COVID-19 on the utilization of covered services, and * Allow initial MCO enrollment

through direct auto-assignment. • Other Changes * Allow additional prescription drugs on the FFS 90-day supply list; * Incorporate COVID-19 symptom review into mobile crisis response processes; * Allow designated application assisters to assist with Medicaid and CHIP applications over the phone with additional representative form; * Relaxed 180-day timely filing limit; and * Temporarily suspend ORP edits (initially 1135 waiver request). (MD, LP, LT) See HFS COVID page: https://www.illinois.gov/hfs/Pages/coronavirus.aspx for SPAs, Appendix K, 1135 request, etc. See https://www.ilga.gov/legislation/publicacts/101/PDF/101-0649.pdf for the Medicaid omnibus with the COVID eligibility changes.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	106,083	106,261	0.168%
Separate CHIP	222,898	224,115	0.546%

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	44,000	4,000	1.4%	0.1%
2016	36,000	4,000	1.2%	0.1%
2017	46,000	5,000	1.5%	0.2%
2018	48,000	6,000	1.6%	0.2%
2019	61,000	7,000	2.1%	0.2%

Percent change between 2018 and 2019
NaN%

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

- ○ Yes
- ◉ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

- ◉ Yes

  2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

  Illinois continues to use a variety of strategies to reach families who speak languages other than English. Fact Sheets are available in many languages. The All Kids Hotline uses a language translation service that allows staff to talk to callers who speak any language. All written client communications are available in both English and Spanish. These strategies are critical to reaching those for whom English is not their primary language. All Kids Application Agents (AKAAs) are also community-based/integrated and many are very active in reaching out to the populations in their respective communities and have their own outreach strategies, as do the MCOs in immigrant and rural communities.

- ○ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

All Kids Application Agents and other assisters are our most effective way to help families apply and enroll into the program.

4. Is there anything else you'd like to add about your outreach efforts?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

_____ %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

◉ Yes

4a. How long is the waiting period?

3 months

4b. Which populations does the waiting period apply to? (Include the FPL for each group.)

The period of being uninsured applies to children in families with income above 209% FPL.

4c. What exemptions apply to the waiting period?

Newborn under age 1 who does not have private or employer-sponsored insurance coverage; Child lost benefits under All Kids Assist, Share or Premium Level 1 in the 12 months prior to the month of application; Premium paid for coverage of the child under a health plan exceeded 5% of household income; Child's parent is determined eligible for a premium tax credit for enrollment in a health plan through the FFM because the employer sponsored insurance in which the family was enrolled is determined unaffordable; The cost of family coverage exceeds 9.5% of the household income; Lost coverage because the employer that had sponsored the coverage stopped offering coverage of dependents; Change in parent's employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance; Child has special health care needs; or Child lost insurance due to the parent's death or the noncustodial parent canceled the insurance as part of a divorce.

4d. What percent of individuals subject to the waiting period meet a state or federal exemption?

- [ ] No

- [ ] N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting data?

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?
This question should only be answered in respect to Separate CHIP.

- (●) Yes

  1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

  18 %

  1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

  83 %

- ( ) No

- ( ) N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- (●) Yes
- ( ) No

3. Do you send renewal reminder notices to families?

- (●) Yes

  3a. How many notices do you send to families before disenrolling a child from the program?

  1

  3b. How many days before the end of the eligibility period did you send reminder notices to families?

  60

- ( ) No

4. What else have you done to simplify the eligibility renewal process for families?

If the state can use electronic information to verify continued eligibility for someone who is 60 days out from their renewal date, we renew coverage for another year, and send out a notice of renewal without a full renewal packet. Beginning in March 2020 and continuing throughout the PHE, we have suspended the mailing of renewal packets for those who could not be verified electronically.

5. Which retention strategies have you found to be most effective?

In addition to continuing coverage throughout the PHE, renewal assistance from MCOs, the Chicago Public Schools and other entities have been effective retention strategies.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

A variety of periodic reports on continued eligibility, program enrollment, redeterminations, reinstatements, and applications.

7. Is there anything else you'd like to add that wasn't already covered?

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2020?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

417164

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

91730

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

325334

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

238762

4. How many applicants were denied CHIP coverage for other reasons?

0

5. Did you have any limitations in collecting this data?

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	21.99%
Denied for eligibility reasons	77.99%
Denials for other reasons	0%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2020?

40516

2. Of the eligible children, how many were then screened for redetermination?

40516

3. How many children were retained in CHIP after redetermination?

40475

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

41

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

11

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

30

4c. How many children were disenrolled for other reasons?

0

5. Did you have any limitations in collecting this data?

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	99.9%
Children disenrolled after redetermination	0.1%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	26.83%
Children disenrolled for eligibility reasons	73.17%
Children disenrolled for other reasons	0%

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2020?

420181

2. Of the eligible children, how many were then screened for redetermination?

420181

3. How many children were retained in Medicaid after redetermination?

396615

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

23566

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4713

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

18853

4c. How many children were disenrolled for other reasons?

0

5. Did you have any limitations in collecting this data?

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	94.39%
Children disenrolled after redetermination	5.61%

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	20%
Children disenrolled for eligibility reasons	80%
Children disenrolled for other reasons	0%

Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or

younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
419	7831	9803	5164

July - September 2020 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
345	6578	8369	4377

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	92	111	59

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	55	77	34

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
65	1161	1323	728

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
30	889	987	559

9. Is there anything else you'd like to add about your data?

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
16969	15858	17865	8751

July - September 2020 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
16159	13148	14469	7069

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
49	161	195	95

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	30	65	26

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
761	2549	3201	1587

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
59	1094	1603	848

9. Is there anything else you'd like to add about your data?

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in Medicaid 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- (●) Yes
- ( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- (●) Families ("the shoebox method")

  2a. What information or tools do you provide families with so they can track cost sharing?

  At approval and renewal, families are sent a letter and a form to complete, along with an envelope to use when submitting receipts for copayments. The copay cap is set at a level low enough so that the copays, along with the 12 months of premiums for a year, will never exceed 5%.

- ( ) Health plans
- ( ) States
- ( ) Third party administrator
- ( ) Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

The systems that providers use to verify eligibility are updated with a message that copays can no longer be charged

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

- ○ Yes
- ◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add that wasn't already covered?

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- ○ Yes
- ◉ No

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- ◉ Yes
- ○ No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- ◉ Yes
- ○ No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

The State of Illinois, Department of Healthcare and Family Services (HFS) does not have separate procedures in place for Preventing or investigating fraud and abuse for CHIP cases. When investigating possible fraud and abuse cases for providers and recipients, HFS reviews both CHIP and Title 19 Medicaid services which were rendered or received. The HFS - Office of Inspector General (OIG) does utilize a variety of techniques to both prevent and detect possible fraud, waste and abuse associated with all types of public assistance including Medicaid, CHIP, cash assistance and food stamps. These activities include provider post-payment compliance audits, provider quality assurance reviews, quality control measurements, client eligibility investigations, fraud prevention investigations, long term care - asset discovery investigations and recipient utilization reviews.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- (●) Yes

  5a. What safeguards and procedures do the Managed Care plans have in place?

  Fraud, waste and abuse written plans are required and incorporated into the respective MCO compliance plans consistent with federal requirements. The written plans are submitted to the State's federally required contractor every three years and to the OIG annually.

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2020?

21

7. How many cases have been found in favor of the beneficiary in FFY 2020?

<11

8. How many cases related to provider credentialing were investigated in FFY 2020?

344

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

0

10. How many cases related to provider billing were investigated in FFY 2020?

62

11. How many cases were referred to appropriate law enforcement officials in FFY 2020?

14

12. How many cases related to beneficiary eligibility were investigated in FFY 2020?

589

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

19

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ◉ Yes

  15a. How do you provide oversight of the contractors?

  The State of Illinois, Department of Healthcare and Family Services - Office of Inspector General has a bureau called the Bureau of Medicaid Integrity. Staff within this bureau work on a daily basis with all external vendors to oversee all program integrity audits, compliance reviews and investigations. Oversight is done by discussions with external vendors, reports on external vendor productivity and detailed review of all invoices billed to the Department by these vendors.

- ○ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

(●) Yes

16a. What specifically are the contractors responsible for in terms of oversight?

HFS contracts with HSAG as the State's federally required external quality review of EQR activities. HSAG tenders their final report to HFS which documents their review and results.

( ) No

17. Is there anything else you'd like to add that wasn't already covered?

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5" group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
722	11694	25293	37915	53991	41751

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	2341	13179	24913	34288	21201

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	2222	12667	24013	32750	19456

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	109	3012	9804	13847	9369

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2020?

8061

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction.

1. Did you collect the CAHPS survey?

- (●) Yes
  - 1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?
    - ( ) Yes
    - (●) No
- ( ) No

Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.
This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...
2020 IL CAHPS_Summary Report_General Child and CCC CAHPS Results.xlsx

2. Which CHIP population did you survey?

- ○ Medicaid Expansion CHIP
- ○ Separate CHIP
- ◉ Both Separate CHIP and Medicaid Expansion CHIP
- ○ Other

3. Which version of the CAHPS survey did you use?

- ◉ CAHPS 5.0
- ○ CAHPS 5.0H
- ○ Other

4. Which supplemental item sets did you include in your survey?
Select all that apply.

- [ ] None
- [x] Children with Chronic Conditions
- [ ] Other

5. Which administrative protocol did you use to administer the survey?
Select all that apply.

- [x] NCQA HEDIS CAHPS 5.0H
- [ ] HRQ CAHPS
- [ ] Other

6. Is there anything else you'd like to add about your CAHPS survey results?

The section of report labeled All Kids is Title XXI

Part 3: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can only develop HSI programs after funding other costs to administer their CHIP State

Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

Illinois covers services provided during the 60 day postpartum period for women who are non-financially ineligible for Medicaid.

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Women who were non-financially ineligible for Medicaid during their pregnancy and whose prenatal services were covered under the unborn SPA.

4. How many children do you estimate are being served by the HSI program?

12579

5. How many children in the HSI program are below your state's FPL threshold?

12579

Computed: 100%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Number of women who received services during the postpartum period of eligibility

7. What outcomes have you found when measuring the impact?

11,955 of 12,579, or 95% of the women accessed services during the postpartum period. This is only slightly lower than the 96% noted in the previous year.

8. Is there anything else you'd like to add about this HSI program?

Postpartum health care supports the health of the mother making her better able to care for her newborn. It's also a time to provide family planning services to the new mothers.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Section 3I.docx

1. What is the name of your HSI program?

Illinois funds services provided under the children's presumptive eligibility period for the time period between the date of application and the date the application is registered.

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Children who qualify for children's presumptive eligibility.

4. How many children do you estimate are being served by the HSI program?

31077

5. How many children in the HSI program are below your state's FPL threshold?

31077

Computed: 100%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The number and percentage of children who received presumptive eligibility and were able to get services that they otherwise would not have had coverage for. There is a larger percentage who received services in real time that may have been turned away without the promise of PE. The lag between the date of service and the date of billing by the provider limits our ability to fully report this number.

7. What outcomes have you found when measuring the impact?

20,400 of 31,077, or 65.6% of children who received presumptive eligibility were able to get services that they would not have had coverage for without this HSI.

8. Is there anything else you'd like to add about this HSI program?

The rate for 2020 Is considerably higher than last years, this may be due to COVID policies implemented in 2020.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

Reduce the number of uninsured children in Illinois.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Children under age 19 in the survey with no health insurance.

4. Numerator (total number)

120039

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Children under age 19 in the survey.

6. Denominator (total number)

2981525

Computed: 4.03%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Our goal last year was to have an ACS state-level uninsured rate of 2.8, but we only achieved 4.03%.

10. What are you doing to continually make progress towards your goal?

Advocate for changes to the Medicaid and CHIP programs to allow coverage for more immigrants.

11. Anything else you'd like to tell us about this goal?

The American Community Survey was the goal's data source.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase access to care

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Our goal is to reduce the Infant Mortality rate by 2%. Infant mortality rate is defined as the rate at which Illinois newborns die during the first year of life, per 1,000 live births.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Infant deaths (statewide 2018)

4. Numerator (total number)

943

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Live births (statewide 2018)

6. Denominator (total number)

144828

Computed: 0.65%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2018

End

mm/yyyy

12 / 2018

8. Which data source did you use?

- ( ) Eligibility or enrollment data
- ( ) Survey data
- (•) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

We did not reach our goal, the FFY2019 rate was 6.1 per 1000 live births the resulting goal for FFY2020 was 5.98. The actual rate for FFY2020 increased to 6.5 per 1000 live births.

10. What are you doing to continually make progress towards your goal?

HFS continues to use predictive analytics to identify women with a previous high cost birth who are currently pregnant. HFS has expanded this algorithm to include identification of other conditions that are associated with a poor birth outcome. This means women experiencing a first birth and who have an identified condition(s) are included in the case finding sent to DHS and the MCO's. Weekly an electronic data exchange transfers data to DHS and to the HFS contracted MCO's to outreach to these women and engage them in early, intensive prenatal care.

11. Anything else you'd like to tell us about this goal?

We will continue to strive for a 2% decrease in Infant Mortality each year.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Reduce the number/percent of children with elevated blood lead levels exceeding 10 mcg/dL

2. What type of goal is it?

- ○ New goal
- ○ Continuing goal
- ◉ Discontinued goal

2a. Why was this goal discontinued?

Illinois is aligning with the federal EBLL of 5mcg/dL and implementing a new goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start
mm/yyyy

/

End
mm/yyyy

/

8. Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Reduce the number/percent of children with elevated blood lead levels that meet or exceed 5 mcg/dL

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Medicaid/CHIP enrolled children, ages 6 and younger, with elevated blood lead levels exceeding 5 mcg/dL. The Illinois data includes capillary and venous tests. It also accounts for test results obtained with handheld analyzers.

4. Numerator (total number)

4275

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Medicaid/CHIP enrolled children (ages 6 and younger) screened for childhood lead poisoning.

6. Denominator (total number)

157333

Computed: 2.72%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The CY2018 rate was 2.93 and the CY2019 goal was 2.83 so the actual rate of 2.72, a decrease of .21, beats the goal.

10. What are you doing to continually make progress towards your goal?

HFS is a member of the Illinois Department of Public Health (IDPH) Lead Poisoning Elimination Advisory Council. IDPH sends test results to HFS' Enterprise Data Warehouse (EDW), this data and the Care Coordination Claims Data (CCCD) are used to make available monthly reports on lead testing and test results which are sent to MCOs as flags on an individual's data so the MCO may follow-up appropriately. Seven years of lead screening information is included.

11. Anything else you'd like to tell us about this goal?

The level of blood lead equaling elevated levels was changed from the old state standard of meeting or exceeding 10mcg/dL to the new Illinois standard of meeting or exceeding 5 mcg/dL

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

In an effort to increase access to care, our goal is to increase the number of children who have received at least one capillary or venous blood lead screening test on or before their second birthday by 10%.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

HFS continuously enrolled children (Title XIX, Title XXI) who are 24 months of age and received at least one capillary or venous blood test on or before their second birthday.

4. Numerator (total number)

47600

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

HFS continuously enrolled children (Title XIX, Title XXI) who are 24 months of age.

6. Denominator (total number)

64940

Computed: 73.3%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The projected goal was 76.83. The actual for CY2019 was 73.30, so the goal was not reached.

10. What are you doing to continually make progress towards your goal?

HFS is a member of the Illinois Department of Public Health (IDPH) Lead Poisoning Elimination Advisory Council. IDPH sends test results to HFS' Enterprise Data Warehouse (EDW), this data is included with the Care Coordination Claims Data (CCCD) and made available monthly to the MCO's. Seven years of lead screening information is included.

11. Anything else you'd like to tell us about this goal?

We will continue to strive for a 10% improvement in the rate of children with lead screening performed by age 2.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increase the use of preventative care

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Eighty percent of children as measured by the CMS-416 guidance will participate in well child screenings.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Per CMS-416 guidance (9/2017), "Line 9 -- Total Eligibles Receiving at Least One Initial or Periodic Screen -- Enter the unduplicated number of individuals under age 21 with at least 90 days continuous enrollment within the federal fiscal year from Line 1b, including those in fee-for-service, prospective payment, managed care, and other payment arrangements, who received at least one documented initial or periodic screen during the year, based on an unduplicated paid, unpaid, or denied claim."

4. Numerator (total number)

710995

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Per CMS-416 guidance revised September 2017, "Line 8--Total Eligibles Who Should Receive At Least One Initial or Periodic Screen--The number of individuals who should receive at least one initial or periodic screen is dependent on each state's periodicity schedule.

6. Denominator (total number)

1276692

Computed: 55.69%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2018

End

mm/yyyy

09 / 2019

8. Which data source did you use?

- ( ) Eligibility or enrollment data
- ( ) Survey data
- (•) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The FFY2019 rate of 55.69 was a slight improvement over the FFY2018 rate of 55.36 but did not meet the interim goal of 59.83 (a 10% annual increase).

10. What are you doing to continually make progress towards your goal?

HFS strengthened its managed care contracts to specify content of care expected for children and implemented a withhold/pay for performance strategy. HFS' Quality Strategy includes measuring well child visits and establishes improvement targets. Bonus payments are available to MCO's to complete the series of recommended visits based on the periodicity schedule for children birth to age 5.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Eighty percent (80%) of enrolled children will be appropriately immunized at age two (less than 36 months of age at the end of the calendar year).

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

HFS continuously enrolled children (Title XIX, Title XXI) who turn 36 months of age by the end of the calendar year and achieve the vaccine series indicated.

4. Numerator (total number)

45880

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

HFS continuously enrolled children (Title XIX, Title XXI) who turn 36 months of age by the end of the calendar year.

6. Denominator (total number)

66142

Computed: 69.37%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The Combo 3 FFY2019 rate of 69.37 is higher than the FFY2018 rate of 65.53 and surpasses the interim goal of 67.25 (a 5% increase over FFY2018)

10. What are you doing to continually make progress towards your goal?

HEDIS CIS Combo 3 immunization's by age 2 is an MCO bonus payment measure. Care Coordination Claims Data (CCCD) are available to MCO's for their enrolled recipients and contains the most recent two years of claims data, and seven years of immunization and lead data - this is updated monthly.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

Illinois Medicaid expanded care coordination to children, their parents, and newly eligible Medicaid enrollees under the Affordable Care Act (ACA). Care coordination for these populations is provided by managed care entities (MCE). Illinois strengthened its managed care contracts to specify content of care expected for children and implemented a withhold/pay for performance (P4P) strategy. These contracts include performance measures that are aligned with a sub-set of Child and Adult Core Set measures. To achieve optimal outcomes and measure performance across programs, HFS selected a uniform set of priority measures for children that support the Quality Strategy goals. This alignment allows for efficiency in reporting as HFS significantly reduced the overall number of measures MCEs are required to report to HFS by creating consistency across programs. HFS uses HEDIS percentiles as benchmarks for P4Ps to drive performance improvement. For accreditation purposes, MCEs report a comprehensive set of HEDIS measures to NCQA. The CCCD files were expanded to include risk flags for selected measure conditions. Recipient-level flags are set when: a) recipients qualify for a measure denominator, or our flag modification to it, and are not in the numerator; and b) recipients receive services from a sister state agency (e.g., DHS' Better Birth Outcomes and Early Intervention programs; DPH Early Hearing Detection and Intervention [EHDI] program - for expedited case management). While not specifically measurement or reporting, HFS puts data into action from both the measures and the multi-state agency data exchange to improve care delivery and care coordination in order to improve health outcomes. HFS annually conducts the CAHPS® 5.0H with CCC supplemental questions for the statewide population of children. The survey over samples for Medicaid and CHIP populations and separate reports are generated for the aggregate, Medicaid-specific and CHIP-specific groups. Focusing on improving birth outcomes, DHS and HFS will continue to share data on women identified as high-risk for a poor birth outcome. First, HFS identifies women as potentially pregnant by analyzing claims for data indicative of pregnancy (e.g., pharmacy claims for prenatal vitamins). Once identified as pregnant a flag is set in a data file transferred weekly to the Department of Human Services (DHS). The list is used to outreach to women and engage them in early and intensive prenatal care through the Family Case Management (FCM) and Better Birth Outcomes (BBO) programs. MCEs receive

information on identified pregnant women to permit case management to women in areas that are not covered by the BBO program. Public Act 93-0536 (305 ILCS 5/5 - 5.23) was enacted with the goal of improving birth outcomes for the over 80,000 births covered by HFS annually. The law states HFS may provide reimbursement for all prenatal and perinatal health care services provided under Medicaid to prevent low birth weight infants, reduce need for neonatal intensive care hospital services, and promote perinatal health. HFS is required to report to the General Assembly on the effectiveness of prenatal and perinatal health care services every two years. The biennial reports identify steps HFS has taken with its partners (other state agencies, advocate groups, maternal and child health experts, local funding resources and others) to address the Perinatal health and health disparities; detail the progress made on priority recommendations in PA93-0536; review the available trend data on infant mortality, low birth weight and very low birth weight outcomes; identify the progress made to address poor birth outcomes through analysis of trend data; and identify next steps in improving birth outcomes. The SMART Act (Public Act 097-0689) also includes a focus on improving birth outcomes. Changes resulting from this 2012 legislation include paying Cesarean deliveries at the normal vaginal rate when there is no indication of medical necessity. Related to care coordination, the legislation mandated the development of a statewide multi-agency initiative to improve birth outcomes and reduce costs associated with poor birth outcomes (e.g., low birth weight, very low birth weight or infant demise). HFS contracts with a federally recognized Quality Improvement Organization, for external utilization review and quality assurance, primarily monitoring inpatient care, and to perform special projects/quality reviews in the fee for service arena. Findings on various components of the review process are available in their ongoing reporting to HFS. HFS contracts with Health Services Advisory Group (HSAG) for the federally required external quality monitoring of managed care. In compliance with the BBA, HFS developed a quality strategy for managed care and contracts with managed care providers require ongoing internal monitoring and quality improvement in the areas of availability and access to care, and quality of care (EQRO). HFS's contracts with managed care entities require meeting performance standards and improving outcomes. HFS established a Medicaid Advisory Committee (MAC) Quality Care Subcommittee to advise the MAC on strategies for improving the Medicaid health care delivery system to improve patient outcomes and deliver services in a cost effective, efficient manner. This subcommittee will: • Review and compare quality metrics, as well as other measures reported by the MCEs, such as medical home assignment,

timely access to care, member satisfaction, and experience of care and coverage; • Review service delivery among MCEs, including provider participation and network adequacy; and • Review evidence-based practices and programs that address social determinants of health that can lead to improved patient care and outcomes. In compliance with legislation (PA 099-0725), HFS developed a consumer-focused quality rating system (report card) with the aid of our EQRO, Health Services Advisory Group (HSAG), The report shows how the Statewide managed care plans compare to one another in key performance areas. The report card includes information indicating the trend of the data. This report is available on-line at https://www.illinois.gov/hfs/SiteCollectionDocumentsIL2019CY2018HealthChoiceIllinoisReportCardStatewideF1.pdf.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will this data become available?

Yes, Illinois has several strategies in place to help us attain our goals and objectives and intends to continue adding to these strategies. HFS is currently reviewing the measure set reported on by the MCO's and adjusting which measures will be withhold measures. The bonus payment methodology and benchmarks are also being reviewed and updated. HFS is just starting the 2021 CAHPS® 5.0H with CCC supplemental questions for the statewide population of children including over samples for Medicaid and CHIP populations. This oversampling allows separate reports to be generated for the aggregate, Medicaid-specific and CHIP-specific groups. The results are analyzed and used to inform our MCO's on area's that need improvement. HFS continues to pursue additional data sources to integrate into the EDW. This provides opportunities to match recipient-level data across sources to improve quality measurement and to enhance care coordination and conduct risk stratification. HFS is interested in securing laboratory results from DPH for recipients covered by HFS. These data would provide useful clinical information to measure outcomes related to service provision, to wraparound case management service and to identify needed intervention services for those identified with abnormal laboratory results. HFS is introducing a comprehensive array of community-based services for children with complex behavioral health needs, consistent with the requirements of the N.B. Consent Decree. Children with complex behavioral health needs will have access to specialized care coordination and intensive services such as: High-Fidelity Wraparound/ Intensive Care Coordination, Intensive Home-Based Services, Respite, Therapeutic Mentoring, and Family Peer Support. This expanded service array will significantly enhance the community-based behavioral health service for children, providing children and families with the services necessary to support their success at home, school, and in the community. HFS anticipates implementing these new services effective July 1, 2021. HFS is updating its IHH program eligibility criteria to target children and adults with chronic physical health conditions, or who are at risk of developing chronic health conditions due to the presence of unmet social or environmental needs (e.g. housing, food security, employment, safety). Under this approach, IHHs will focus on addressing social determinants of health and health disparities for the Department's most medically complex individuals. IHHs will demonstrate positive health outcomes for participants through enhanced engagement, outreach, disease management, and care coordination services that are

individualized, person-centered, integrated, and community based. HFS does not anticipate implementing IHHs before July 1, 2021.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, special healthcare needs, or other emerging healthcare needs.) What have you discovered through this research?

Illinois' MCEs have performed focused quality studies on children's health issues, such as appropriate care for asthma; improving the rate of well child visits, lead screening and childhood immunizations; as well as ensuring that content of care is in compliance with well child screening guidelines for children under age three. MCEs are engaging in a collaborative performance improvement project (PIP) focused on access to behavioral healthcare. Public Act 93-0536 (305 ILCS 5/5 - 5.23) was enacted with the goal of improving birth outcomes for the over 80,000 births covered by HFS annually. The law states that HFS may provide reimbursement for all prenatal and perinatal health care services that are provided under Medicaid for the purpose of preventing low birth weight infants, reducing the need for neonatal intensive care hospital services, and promoting perinatal health. Additionally, HFS was required to develop a plan for prenatal and perinatal health care for presentation to the General Assembly by January 1, 2004. HFS is required to report to the General Assembly on the effectiveness of prenatal and perinatal health care services, on or before January 1, 2006, and every two years thereafter. The biennial reports identify steps HFS has taken with its partners (other state agencies, advocate groups, maternal and child health experts, local funding resources and others) to address the Perinatal health care needs and racial health disparities in Illinois; detail the progress made in addressing the priority recommendations as outlined in the Report to the General Assembly as a result of Public Act 93-0536; review the available trend data on infant mortality, low birth weight and very low birth weight outcomes; identify the progress made to address poor birth outcomes through analysis of trend data; and identify next steps in improving birth outcomes. Due to budget and staff constraints the 2020report due date was extended. For State Fiscal Year (SFY) 2020, the Illinois Department of Healthcare and Family Services (HFS) contracted with its External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG), to provide quantitative information about prenatal care and associated birth outcomes among women. The purpose of the analysis is to address the following study questions regarding Medicaid-paid births between July 1, 2018 through June 30, 2019: • To what extent do women with births paid by Medicaid receive early and adequate prenatal care? • What clinical outcomes are associated with Medicaid-

paid births? • To what extent do birth outcomes vary by the mother's demographics (e.g., age, race/ethnicity, urbanicity)? This document outlines the data requirements for the following types of data pertaining to the Illinois Medicaid member population that HFS will extract from its data warehouse or obtain from the Department of Public Health and then submit to HSAG for the study. • Member enrollment data • Member demographic data • Birth registry data The study was put on hold when HFS was unable to get all the vital records necessary.

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 485,935,726	**$** 484,435,405	**$** 517,763,533

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 134,848,361	**$** 85,862,412	**$** 85,518,555

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$	**$**	**$**

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 23,382,813	**$** 0	**$** 0

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2020	FFY 2021	FFY 2022
Managed Care	485935726	484435405	517763533
Fee for Service	134848361	85862412	85518555
Other benefit costs			
Cost sharing payments from beneficiaries	23382813	0	0
Total benefit costs	644166900	570297817	603282088

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?
This includes wages, salaries, and other employee costs.

2020	2021	2022
$ 14,953,558	**$** 23,868,916	**$** 25,249,421

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 15,895,848	**$** 25,373,003	**$** 26,840,499

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

5. How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 1,927,360	**$** 3,076,458	**$** 3,254,391

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 2,951,632	**$** 4,711,404	**$** 4,983,897

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2020	FFY 2021	FFY 2022
Personnel	14953558	23868916	25249421
General administration	15895848	25373003	26840499
Contractors and brokers	0	0	0
Claims processing	0	0	0
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	1927360	3076458	3254391
Other administrative costs	2951632	4711404	4983897
Total administrative costs	35728398	57029781	60328208
10% administrative cap	66377919.33	63366424.11	67031343.11

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2020	**FFY 2021**	**FFY 2022**
Total program costs	679895298	627327598	663610296
eFMAP	76.60	65.67	65.76
Federal share	520799798.27	411966033.61	436390130.65
State share	159095499.73	215361564.39	227220165.35

8. What were your state funding sources in FFY 2020?
Select all that apply.

- [x] State appropriations
- [x] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [x] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1. How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
221090	245448	262335

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
Round to the nearest whole number.

2020	2021	2022
$ 164	**$** 164	**$** 164

	FFY 2020	FFY 2021	FFY 2022
PMPM cost	164	164	164

Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1. How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
61220	63166	62913

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020	2021	2022
$ 113	**$** 113	**$** 113

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost	113	113	113

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

• Claims Processing Costs - The Department compiles claims processing costs within the general administration total on the CMS21 quarterly claim. • Actual and Projected Expenditures - Actual expenditures reported stem from the Department's CMS21 quarterly claim (cashflow basis), whereas projected expenditures are based on projected member months. The department does not have a mechanism to estimate the future timeliness of payments from the comptroller due to state cashflow constraints.

2. Optional: Attach any additional documents here.

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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

COVID has had a devastating impact on the physical, behavioral, and economic health of our state. It has had a similar impact on our eligibility system and staff. However, despite these challenges, Illinois is committed to providing and continues to provide healthcare to all eligible Illinoisans, including low-income children and families.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

Frequent federal policy changes targeted to immigrants has had a chilling effect on enrollment in Illinois. Changes to Public Charge policy have especially raised concerns among immigrants to the point that they are hesitant to apply for public benefits, even state funded public benefits. This is even true for those who are legal immigrants for more than five years. Updating the hardware and software that is the technical foundation of our Integrated Eligibility System has been a long-standing challenge. Frequent delays in the schedule have affected our ability to make system performance improvements and the speed with which we address system defects. Quickly adjusting to the COVID Public Health Emergency has been our biggest challenge. Our Integrated Eligibility System usually requires months of planning, development and testing before changes can be made to reflect new eligibility processing policy and procedures. In order to comply with the Maintenance of Effort prohibition against taking adverse actions against enrolled customers and to be sure that anyone who qualified for coverage got it quickly, we used a creative method for assuring that coverage wasn't ended or reduced. We used an end of day process to block each day's changes that would lead to an inappropriate reduction or cancellation of medical coverage. This allowed us to quickly comply with the MOE requirement in April 2020 without requiring months of system change work. However, federal changes and reinterpretations of the MOE requirement were released in June and November and presented us with the challenge of conducting additional rounds of MOE programming changes which we are still in the process of completing. Additionally, being distracted by changes in policy, procedures, and systems to address COVID delayed many of our scheduled changes to improve system performance and address system defects. We will be digging out from these delays for some time and we know that unwinding COVID flexibilities at the end of the PHE will further aggravate this situation.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

We made substantial progress in reducing the backlog of applications on hand 46 days or more. In January of 2019 we had 147,000 backlogged apps. As of the end of November 2020 we have just over 12,000, a 91% reduction. Despite the initially disruptive impact of COVID and the Public Health Emergency, COVID eligibility flexibilities allowed us to achieve this progress by simplifying the eligibility process for applicants and state eligibility workers. The federal Maintenance of Effort prohibition against taking adverse action against enrolled customers also allowed us to focus on application processing.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

We are considering Medicaid and CHIP State Plan Amendments to move children enrolled in our CHIP separate state program to the CHIP Medicaid Expansion. We first need state legislative authority to make this change.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

6. Optional: Attach any additional documents here.

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