



Illinois CARTS FY2021 Report

Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

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

158



FPL ends at

209

Premium starts at

\$ 15



Premium ends at

\$ 40

FPL starts at

210



FPL ends at

318

Premium starts at

\$ 40



Premium ends at

\$ 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

158



FPL ends at

209

Premium starts at

\$ 180



Premium ends at

\$ 480

FPL starts at

210



FPL ends at

318

Premium starts at

\$ 480



Premium ends at

\$ 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.



Managed Care



Primary Care Case Management



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 HCBStelehealth 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 Covid19; * 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 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 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. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

☒ Yes

☐ No

21. 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 HCB Steele health 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 request 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.

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 2020	Number of children enrolled in FFY 2021	Percent change
Medicaid Expansion CHIP	106,261	109,944	3.466%
Separate CHIP	224,115	226,711	1.158%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

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. Due to the impacts of the COVID-19 PHE on collection of ACS data, the 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
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%
2020	Not Available	Not Available	Not Available	Not Available

Percent change between 2019 and 2020
Not Available

1. What are some reasons why the number and/or percent of uninsured children has changed?

NA

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

2a. What are some reasons why the American Community Survey estimates might not reflect the number of uninsured children in your state?

Supplemental Tables 2019 ACS 1-Year Supplemental Estimates with a Population Threshold of 20,000 or More Notice: Due to the impact of the COVID-19 pandemic, the Census Bureau is changing the 2020 American Community Survey (ACS) release. Instead of providing the standard 1-year data products, the Census Bureau will release a series of experimental estimates from the 1-year data. Therefore, we will not have 2020 Supplemental Tables and will continue to link to the 2019 Supplemental Tables.

☐ 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?

11.81

%

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)?

77.22

%

☐ 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

☒ 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 2021?

Don't include applicants being considered for redetermination - this data will be collected in Part 3.

146082

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.

93226

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.

52856

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

200897

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

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	63.82%
Denied for eligibility reasons	36.18%
Denials for other reasons	

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 2021?

121504

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

91724

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

91724

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.

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

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.

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

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	100%
Children disenrolled after redetermination	

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

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 2021?

702456

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

584969

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

584969

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.

4a. How many children were disenrolled for procedural reasons?

This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

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.

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

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	100%
Children disenrolled after redetermination	

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

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 last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on 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): included in 2020 report.

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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

Ages 0-1

419

Ages 1-5

7831

Ages 6-12

9803

Ages 13-16

5164

July - September 2020 (6 months later): included in 2020 report.

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

345

Ages 1-5

6578

Ages 6-12

8369

Ages 13-16

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): to be completed this year.
This year, please report data about your cohort for this section

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

331

6277

8161

4261

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

<11

146

134

69

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

<11

80

91

43

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

82

1413

1597

870

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

42

1064

1181

655

July - September of 2021 (18 months later): to be completed this year
This year, please report data about your cohort for this section.

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

320

Ages 1-5

6064

Ages 6-12

7942

Ages 13-16

4166

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

Ages 0-1

11

Ages 1-5

172

Ages 6-12

149

Ages 13-16

89

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

<11

Ages 1-5

95

Ages 6-12

94

Ages 13-16

51

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

90

Ages 1-5

1600

Ages 6-12

1801

Ages 13-16

945

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

41

Ages 1-5

1141

Ages 6-12

1290

Ages 13-16

698

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 last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This 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 2021. 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 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 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): included in 2020 report

You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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): included in 2020 report

You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

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): to be completed this year
This year, please report data about your cohort for this section.

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

15841

12874

14235

6960

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

112

316

338

159

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

<11

85

113

58

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

1073

2811

3505

1728

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

73

1128

1669

877

July - September of 2021 (18 months later): to be completed next year
This year, please report data about your cohort for this section.

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

15445

Ages 1-5

12491

Ages 6-12

13813

Ages 13-16

6768

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

Ages 0-1

195

Ages 1-5

430

Ages 6-12

456

Ages 13-16

214

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

<11

Ages 1-5

108

Ages 6-12

162

Ages 13-16

72

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

1386

Ages 1-5

3080

Ages 6-12

3809

Ages 13-16

1865

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

104

Ages 1-5

1128

Ages 6-12

1655

Ages 13-16

858

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

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, 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 2021?

504

7. How many cases have been found in favor of the beneficiary in FFY 2021?

71

8. How many cases related to provider credentialing were investigated in FFY 2021?

404

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2021?

0

10. How many cases related to provider billing were investigated in FFY 2021?

161

11. How many cases were referred to appropriate law enforcement officials in FFY 2021?

18

12. How many cases related to beneficiary eligibility were investigated in FFY 2021?

858

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2021?

<11

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 OIG's Bureau of Medicaid Integrity work daily 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 reviews 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).

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 2021?

Ages 0-1

52367

Ages 1-2

143617

Ages 3-5

209281

Ages 6-9

264755

Ages
10-14

341338

Ages
15-18

242134

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 2021?

Ages 0-1

354

Ages 1-2

20872

Ages 3-5

78445

Ages 6-9

129479

Ages
10-14

155830

Ages
15-18

88450

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 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
303	19884	73718	120050	144366	76774

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 2021?

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
34	609	14526	43124	53249	36431

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 2021?

25784

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.

Data is from the CMS Generated Reporting of State Form CMS-416 Data Using T-MSIS

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. For the 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to AHRQ.

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...

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
- ☒ Children with Chronic Conditions
- ☐ Other

5. Which administrative protocol did you use to administer the survey?

Select all that apply.

- ☒ NCQA HEDIS CAHPS 5.0H
- ☐ HRQ CAHPS
- ☐ Other

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

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.

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?

11472

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

11054

Computed: 96.36%

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?

11,054 of 11,472, or 96.36% of the women accessed services during the postpartum period. This is slightly higher than the 95.04% 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...

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?

32813

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

20818

Computed: 63.44%

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?

20,818 of 32,813, or 63.44% 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 lower than last years 65.64%, this may be due to the COVID Pandemic.

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...

1. What is the name of your HSI program?

A SPA was approved 9/15/2021, to implements a Health Services Initiative (HSI) to extend the postpartum period from 60-days to 12 months for women whose newborns had been covered as targeted low-income children from conception to birth. The effective date is 03/01/2020

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?

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

Computed:

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.

• Prenatal and Postpartum Care: Postpartum Care (PPC-AD) • Postpartum Depression Screening and Follow-up (PDS-E) • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

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

We do not have outcomes for these measures at this time.

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

SPA was approved 9/15/2021, Reporting will begin with the next CARTS report in 2022

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).

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.

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.

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 eligible children 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?

We are unable to report the uninsured numbers due to the American Community Survey not having current estimates. 2019 ACS 1-Year Supplemental Estimates with a Population Threshold of 20,000 or More
Notice: Due to the impact of the COVID-19 pandemic, the Census Bureau is changing the 2020 American Community Survey (ACS) release. Instead of providing the standard 1-year data products, the Census Bureau will release a series of experimental estimates from the 1-year data. Therefore, we will not have 2020 Supplemental Tables and will continue to link to the 2019 Supplemental Tables.

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, rates are 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 2019)

4. Numerator (total number)

790

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 2019)

6. Denominator (total number)

140145

Computed: 0.56%

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?

We exceeded our goal, the FFY2020 rate was 6.5 per 1000 live births the resulting goal for FFY2021 was 6.37. The actual rate for FFY2021 decreased to 5.6 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 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)

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)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 2020

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?

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?

Data for this goal is currently unavailable due to problems with the computerized transfer of data from and to our sister agency the Department of Public Health

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%.

To increase by 10% the percentage of CHIP/Medicaid continuously enrolled children who receive at least one capillary or venous blood lead screening test on or before their second birthday.

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.

CHIP/Medicaid 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)

44757

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.

CHIP/Medicaid continuously enrolled children (Title XIX, Title XXI Only) who are 24 months of age.

6. Denominator (total number)

62652

Computed: 71.44%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 2020

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 75.98. The actual rate for CY2020 was 71.44, 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 rate of children with lead screening performed by age of two.

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 preventive 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)

562980

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)

1272933

Computed: 44.23%

7. What is the date range of your data?

Start

mm/yyyy

10

/

2019

End

mm/yyyy

09

/

2020

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 FFY2020 rate of 44.23 was a large decrease from the FFY2019 rate of 55.69. We did not meet the interim goal of 60.12 (a 10% annual increase). This is likely due to the COVID Pandemic.

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.

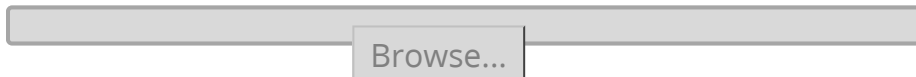
11. Anything else you'd like to tell us about this goal?

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).

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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 vaccine combo 3 (HEDIS® CIS).

4. Numerator (total number)

44389

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)

66290

Computed: 66.96%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 2020

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 FFY2021 rate of 66.96% is lower than the FFY2020 rate of 69.56% and does not meet the interim goal of 71.08% (a 5% increase over FFY2020). The decrease is likely due to the COVID Pandemic.

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

HEDIS CIS Combo 3 immunizations 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

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

1. Briefly describe your goal for this objective.

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?

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

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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).

Do you have another Goal in this list?

Optional

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

1. Briefly describe your goal for this objective.

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?

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

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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...

Do you have another Goal in this list?

Optional

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

1. Briefly describe your goal for this objective.

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?

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 eligible children in the last federal fiscal year.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

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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...

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://www2.illinois.gov/hfs/info/reports/Pages/default.aspx>

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 withheld 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. The Illinois Department of Human Services (DHS) Bureau of Maternal Child Health (BMCH) aims to facilitate case management services to pregnant and postpartum women, and infants; and high-risk infants and children up to age 2, statewide, with the goal of reducing infant and maternal mortality and morbidity rates at both the state and local level with an emphasis on addressing racial/ethnic disparities in outcomes. Services must be provided in a culturally sensitive manner and, acknowledge and respect the differences among the populations served (ethnicity, race, religion, age, gender, abilities, language and other characteristics). Family Connects is a program that is currently being piloted in the Chicagoland area, with plans to expand statewide. It is an evidence-based universal approach for supporting newborns and their families, contributing to a healthy and encouraging foundation for future success in the child's life. The first of its kind in the state of Illinois, it provides between one and three nurse home visits to every family with a newborn beginning at about three weeks of age, regardless of income or demographic risk. Using a tested screening tool, the nurse measures newborn and maternal health and assesses strengths, interests and needs to effectively link the family to community resources. Family Case Management (FCM) is a statewide program that provides comprehensive service coordination to improve the health, social, educational, and developmental needs of pregnant and postpartum women and infants (0 -12 months) from low-income families in the communities of Illinois. The High Risk Infant Follow Up Program (HRIF) is a statewide program for infants and children (ages 0 -2 years old) who are referred via the Illinois Department of Public Health (IDPH) Adverse Pregnancy Outcomes Reporting System (APORS) or based on assessments done in the FCM program which determines: that the infant has been diagnosed with a serious medical condition after newborn discharge, when maternal alcohol or drug addiction has been diagnosed, or when child abuse or neglect has been indicated based on investigation by the Illinois Department of Children and Family Services. The primary goals of HRIF are to: minimize disability in high-risk infants by early identification of possible conditions requiring further evaluation, diagnosis, and treatment; promote optimal growth and development of infants; teach family care of the high-risk infant; and Decrease the stress and potential for abuse in the family setting of the high-risk infant. Innovations to ImPROve Maternal OuTcomEs in Illinois (IPROMOTE-IL), based at the University of Illinois at Chicago (UIC), is collaborating with IDPH's Office of Women's Health and Family Services/Title V on a multi-faceted initiative aimed at improving maternal

health and reducing maternal mortality and severe maternal morbidity during pregnancy and through one year postpartum. It is funded by a \$9.5 million, five-year grant from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). IPROMOTE-IL will: 1) establish a maternal health taskforce; 2) improve statewide maternal health data and surveillance; and, 3) implement five innovative training and service delivery projects to improve maternal health care in Illinois. These projects include: a) provider training on obstetric hemorrhage and maternal hypertension and protocols for pregnant and postpartum women seeking care in the emergency department; b) implementing a birth equity initiative; c) training home visitors on women's health needs during pregnancy and postpartum; d) training obstetric providers on screening and treatment of perinatal mental and behavioral health disorders; and, e) designing and implementing an innovative two-generation medical home for postpartum care. A robust performance monitoring plan is proposed to document progress toward improving maternal health outcomes and reducing disparities over five years in Illinois. The funding also will facilitate the design and implementation of a first-of-its-kind, two-generation postpartum clinic and research and training center at UIC. The clinic will serve postpartum women and their newborns simultaneously. Nationally, more than 90% of newborns receive routine care. However, postpartum women are much less likely to receive postpartum care, particularly women with low incomes. Through the newly signed HB 135 (July 2021), all Illinoisans can now access hormonal birth control over the counter after undergoing screening by a pharmacist. Implantable Long-acting reversible contraceptives are also available now immediately after birth to all women delivering in Illinois hospitals, helping to prevent unintended pregnancies. Illinois is also implementing Pathways to Success a program for Medicaid enrolled children under the age of 21 in Illinois who have complex behavioral health needs and require intensive services and support. The program provides access to an evidence-informed model of intensive care coordination and additional home and community-based services. Pathways is targeted to launch on March 1, 2022.

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 2020 report 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.

Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Tell us how much you spent on your CHIP program in FFY 2021, and how much you anticipate spending in FFY 2022 and 2023.

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 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

\$ 582,759,761

2022

\$ 568,300,742

2023

\$ 580,447,683

2. How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

\$ 153,028,849

2022

\$ 111,911,068

2023

\$ 95,632,029

3. How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

\$ 0

2022

\$ 0

2023

\$ 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

\$ 1,152,233

2022

\$ 11,890,962

2023

\$ 47,274,909

Table 1: Benefits Costs

This table is auto-populated with the data you entered above.

	FFY 2021	FFY 2022	FFY 2023
Managed Care	582759761	568300742	580447683
Fee for Service	153028849	111911068	95632029
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	1152233	11890962	47274909
Total benefit costs	736940843	692102772	723354621

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 2021? How much do you anticipate spending in FFY 2022 and 2023?

This includes wages, salaries, and other employee costs.

2021

\$ 10,558,618

2022

\$ 28,140,303

2023

\$ 27,969,358

2. How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 12,667,823

\$ 33,761,651

\$ 33,556,558

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

4. How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$

\$

\$

5. How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 0

\$ 0

\$ 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 1,221,458

\$ 3,255,369

\$ 3,235,594

7. How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021

2022

2023

\$ 1,074,558

\$ 2,863,858

\$ 2,846,461

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 2021	FFY 2022	FFY 2023
Personnel	10558618	28140303	27969358
General administration	12667823	33761651	33556558
Contractors and brokers	0	0	0
Claims processing			
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	1221458	3255369	3235594
Other administrative costs	1074558	2863858	2846461
Total administrative costs	25522457	68021181	67607971
10% administrative cap	81626264.11	74257872	69867200.33

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 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

FMAP Table	FFY 2021	FFY 2022	FFY 2023
Total program costs	762463300	760123953	790962592
eFMAP	65.67	65.76	65
Federal share	500709649.11	499857511.49	514125684.8
State share	261753650.89	260266441.51	276836907.2

8. What were your state funding sources in FFY 2021?

Select all that apply.

☒

State appropriations

☐

County/local funds

☐

Employer contributions

☐

Foundation grants

☐

Private donations

☐

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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021

2022

2023

231027

273377

268474

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

Round to the nearest whole number.

2021

2022

2023

\$ 180

\$ 180

\$ 180

	FFY 2021	FFY 2022	FFY 2023
PMPM cost	180	180	180

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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021

2022

2023

83805

70493

69229

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?

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.

2021

2022

2023

\$ 115

\$ 115

\$ 115

	FFY 2021	FFY 2022	FFY 2023
PMPM cost	115	115	115

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

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2. 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).

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

COVID-19 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, Illinois was swift and responsive to the evolving needs of our customers, providers, and staff. We adopted a broad array of flexibilities to ensure coverage during this period. We are committed to keeping equity at the center of our policies and decision making. And, despite the challenges we face, Illinois remains committed to providing healthcare to all eligible Illinoisans, including low-income children and families.

2. What's the greatest challenge your CHIP program has faced in FFY 2021?

Quickly adjusting to the COVID-19 Public Health Emergency (PHE) has been our biggest challenge. Our Integrated Eligibility System requires months of planning, development and testing before changes can be made to reflect new eligibility processing policy and procedures. To comply with the Maintenance of Effort (MOE) prohibition against taking adverse actions against enrolled customers we used a creative method for assuring that coverage wasn't ended or reduced. We used an end of day process to block any change that would lead to an inappropriate reduction or cancellation of medical coverage under the PHE MOE. 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, needing to address changes in policy, procedures, and systems to address COVID-19 delayed many of our scheduled changes to improve system performance and address system defects. We will be working through the impact of these delays for some time and unwinding COVID-19 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 2021?

In September 2021, Illinois became the first state to provide full benefit coverage with continuous eligibility for 12 months postpartum (from 60 days) regardless of immigration status through a CHIP Health Service Initiative (HSI) amendment. This first in the nation policy change was taken to benefit children's health. Research shows that when mothers do not have access to care for mental health, substance use disorder, or other medical conditions, they have limited resources to fully respond to their child's health needs. Untreated postpartum depression or substance use disorder can lead to child abuse and neglect, disruption in parental attachment, and adversely impact the child's development. Children are less likely to access preventive care, attend well-child visits, complete immunization schedules, and more likely to experience avoidable hospitalizations when their parent does not have access to coverage. The CHIP HSI provides children with access to these important health benefits regardless of their mother's immigration status. We are incredibly grateful to our federal partners for approving this important change. Additionally, 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 2021 we have just over 2,800, a 98% 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. We believe this all works in the best interest of the customers we serve.

4. What changes have you made to your CHIP program in FFY 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

In addition to the postpartum CHIP HSI change described above, we have Medicaid and CHIP State Plan Amendments pending with CMS to move children enrolled in our CHIP separate state program to the CHIP Medicaid Expansion effective July 1, 2022. Illinois initially received legislative authority and submitted a State Plan Amendment in September 2021 with a retroactive effective date to receive federal matching dollars for the Children Aging Out of CHIP that the state had been keeping covered with all state dollars during the Public Health Emergency to mirror the federal Medicaid maintenance of effort provision. It was since determined that the transition should have a prospective effective date and that Illinois could use 1115 waiver authority to request expenditure authority for Children Aging Out of CHIP back to the start of the Public Health Emergency. This change will have many positive impacts for our customers, including eliminating premiums and the new applicant 90-day waiting period, allowing enrollment in managed care to provide access to care coordination services, and coverage of EPSDT services. The transition will also simplify vaccine administration for providers by simplifying their eligibility determinations for the Vaccines for Children's program.

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

We remain committed to meeting the challenges of the COVID-19 PHE, providing healthcare to all eligible Illinoisans, including low-income children and families, and making our customers and equity the center of everything we do. When it was initially interpreted that the PHE MOE did not apply to Children Aging Out of CHIP or postpartum women regardless of immigration status, Illinois used all-state dollars to implement a state funded PHE MOE for these individuals. The CHIP HSI, 1115 authority, and CHIP to Medicaid SPAs discussed above make federal match available to keep these individuals covered for all or some of the COVID-19 PHE. We appreciate our federal partners' commitment to health coverage and willingness to work with us throughout the COVID-19 pandemic.

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.

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