Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs

ILLINOIS MEDICAID
1915(b) Managed Care Waiver
Managed Long-Term Services and Supports
Renewal CY2024-CY2029

(Waiver #IL-0001.R02.00)

Submitted October 1, 2024
(Revised December 17, 2024)

MMA Amendment Version
July 18, 2005

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Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State** of Illinois requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Managed Long Term Services and Supports (MLTSS) Waiver. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

___ initial request for new waiver. All sections are filled.

___ amendment request for existing waiver, which modifies Section/Part

__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

__ Document is replaced in full, with changes highlighted

X renewal request

__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

X The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is **X** replaced in full

_ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

_ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages

Section B is **X** replaced in full

_ carried over from previous waiver period. The State:

__ assures there are no changes in the Monitoring Plan from the previous waiver period.

_ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver renewal is requested for a period of five (5) years; effective January 1, 2025 and ending December 31, 2029. (For beginning date for an initial or

renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is Kimberley Cox and can be reached by telephone at (773) 355-9581, or e-mail at kimberley.cox@illinois.gov. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The single qualifying Indian Health Service provider in Illinois is the American Indian Health Service of Chicago, Inc. (AIHSC). In accordance with the Illinois State Medicaid Plan, the Illinois Department of Healthcare and Family Services' (HFS) process for notification of changes in the Illinois Medicaid program was established in collaboration with AIHSC. HFS provides written notification via email of proposed changes that describe purpose, anticipated impact on the AIHSC, and request for comment and input. HFS provides assurance with the requirements of 42 CFR 438.14(5)(i).

Over the course of Illinois' Managed Long-Term Services and Supports (MLTSS) 1915(b) Waiver, AIHSC was notified of the initial waiver request, amendments to the waiver, the first waiver renewal, and most recently was notified on September 17, 2024 of this second five-year waiver renewal request. AIHSC has not had comments on the MLTSS 1915(b) Waiver. (For context, most current data indicates there are just over 1,900 dual-eligible American Indian/Alaskan Native Medicaid managed care enrollees in the State of Illinois.)

Program History
For renewal waivers, please provide a brief history *of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).*

In 2013, HFS submitted to the Centers for Medicare & Medicaid Services (CMS) the initial 1915(b) waiver application to implement the Managed Long-Term Services and Supports (MLTSS) Waiver requiring mandatory enrollment of dual-eligible beneficiaries into Medicaid managed care to receive home and community based services (HCBS) authorized under 1915(c) waiver authorities, or institutional long-term care services. The 1915(b) waiver provided authority for mandatory enrollment of dual-eligible beneficiaries into Illinois' Medicaid managed care program. HFS also concurrently implemented a voluntary pathway for these beneficiaries to opt to receive HCBS and institutional long-term care services under federal 1915(a) managed care authority through the Medicare Medicaid Alignment Initiative (MMAI) demonstration, which is a special initiative allowing for the State, CMS (Medicare and Medicaid) and managed care organizations (MCOs) to have a single contract for all services provided by the MCO. The MMAI initiative ends December 31, 2025. Beginning January 1, 2026, based on CMS' approval, HFS intends to continue that voluntary and fully integrated model of care for dual-eligible beneficiaries through statewide contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs).

The State has excluded individuals opting to receive services through the MMAI demonstration from mandatory enrollment into the 1915(b) waiver as those individuals have voluntarily chosen to receive all their Medicaid and Medicare services, including HCBS 1915(c) and institutional long-term care services, through the MMAI demonstration and future D-SNP managed care program.

An amended MLTSS Waiver was submitted in April 2016 and approved by CMS in June 2016. Illinois' MLTSS Waiver went into effect July 1, 2016 in the greater Chicago area.

The MLTSS Waiver was amended to expand statewide; statewide expansion went into effect July 1, 2019. The expansion was part of the State's comprehensive strategy to utilize managed care coordination to enhance quality, improve outcomes and to best manage costs without compromising quality of and access to care for additional populations.

Dual-eligible beneficiaries receiving institutional or community-based long-term services and supports, who opt out of the MMAI (and in the future opt out of a D-SNP health plan) are/will be required to enroll in HFS' Medicaid managed care program, HealthChoice Illinois, under the MLTSS Waiver unless they meet an eligibility exclusion. These beneficiaries will have the choice to enroll with a HealthChoice Illinois contracted managed care organization (MCO) to receive covered Medicaid MLTSS services.

HFS' goals were and continue to be redesigning the health care delivery system for dual-eligible beneficiaries with a focus on improving care delivery and health outcomes, shifting long-term care service utilization from nursing facility services to home and community-based services, and increasing Medicaid beneficiary participation in risk-based managed care.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a. _X_ **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. ___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. ___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the

Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. _X_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

__ MCO
_X_ PIHP
___ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a.___ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b._X_ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

c._X_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

d.___ **Section 1902(a)(4) -** To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

e.___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a.___ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b._X_ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

_X_ The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

c.___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

d.___ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ___ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f.___ **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement**. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

_X_ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
___ **Open** cooperative procurement process (in which any qualifying contractor may participate)
___ **Sole source** procurement
___ **Other** (please describe)

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

___ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
_X_ Two or more PIHPs.
___ Two or more PAHPs.
___ Other: (please describe)

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

___ Beneficiaries will be limited to a single provider in their service area (please define service area).
___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

_X_ **Statewide** -- all counties, zip codes, or regions of the State
___ **Less than Statewide**

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Region 1, Northwestern Counties: Boone, Bureau, Carroll, DeKalb, Fulton, Henderson, Henry, Jo Daviess, Knox, LaSalle, Lee, Marshall, Mercer, Ogle, Peoria, Putnam, Rock Island, Stark, Stephenson, Tazewell, Warren, Whiteside, Winnebago, Woodford **Region 2, Central Counties:** Adams, Brown, Calhoun, Cass, Champaign, Christian, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Greene, Hancock, Iroquois, Jersey, Livingston, Logan, McDonough, McLean, Macon, Macoupin, Mason, Menard, Montgomery, Morgan, Moultrie, Piatt, Pike, Sangamon, Schuyler, Scott, Shelby, Vermilion **Region 3, Southern Counties:** Alexander, Bond, Clay, Clinton, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson,	PIHP	**STATEWIDE:** • Aetna Better Health • Blue Cross Blue Shield of Illinois • Meridian Health Plan of Illinois • Molina Healthcare of Illinois **COOK COUNTY ONLY:** • CountyCare

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Lawrence, Madison, Marion, Massac, Monroe, Perry, Pope, Pulaski, Randolph, Richland, Saline, St. Clair, Union, Wabash, Washington, Wayne, White, Williamson **Region 4:** Cook County **Region 5, Collar Counties:** DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will		

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program:

___ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

___ Mandatory enrollment
___ Voluntary enrollment

___ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

___ Mandatory enrollment
___ Voluntary enrollment

_X_ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

_X_ Mandatory enrollment
___ Voluntary enrollment

- Only those blind or disabled adults who are:
  - Age 21 or older at the time of enrollment;
  - Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D;
  - Receiving full Medicaid benefits;
  - Eligible for and receiving long-term services based on assessed need for nursing facility level of care including:
    - Nursing Facility residents; or
  - Individuals participating in the following 1915 (c) waivers: Persons who are Elderly, Persons with Disabilities, Persons with HIV/AIDS, Persons with Brain Injury, and Persons residing in Supportive Living Facilities; and
  - Have opted out of the MMAI (effective 1/1/2026, opted out of DSNP).

___ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

___ Mandatory enrollment
___ Voluntary enrollment

_X_ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

_X_ Mandatory enrollment

___ Voluntary enrollment

- Only those aged and related populations are part of this waiver who are:
  - Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D;
  - Receiving full Medicaid benefits;
  - Eligible for and receiving long-term services based on assessed need for nursing facility level of care including:
    - Nursing Facility residents; or
    - Individuals participating in the following 1915 (c) waivers: Persons who are Elderly, Persons with Disabilities, Persons with HIV/AIDS, Persons with Brain Injury, and Persons residing in Supportive Living Facilities; and
  - Have opted-out of the MMAI (effective 1/1/2026, opted out of DSNP).

___ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

___ Mandatory enrollment
___ Voluntary enrollment

___ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

___ Mandatory enrollment
___ Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

___ **Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

_X_ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

_X_ **Other Insurance--**Medicaid beneficiaries who have other health insurance.

- Those who have high third-party liability are excluded from the waiver.

_X_ **Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

- Individuals residing in ICF/MR facilities are excluded from participation in the waiver. Individuals residing in Nursing Facilities are included in the waiver.

_X_ **Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program

- Those enrolled in the MMAI are excluded from the waiver.

___ **Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

_X_ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

- Individuals enrolled in the Adults with Developmental Disabilities HCBS waiver are excluded from participation in the waiver. Individuals in the following HCBS waivers are included in this waiver: Persons who are Elderly, Persons with Disabilities, Persons with HIV/AIDS, Persons with Brain Injury, and Persons residing in Supportive Living Facilities.

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

- American Indian/Alaskan Native beneficiaries that meet the waiver criteria are not excluded from participation in the waiver but may voluntarily enroll in the waiver.

_X_ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

_X_ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

_X_ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

- _X_ **Other** (Please define):
  - Individuals not in the AABD category of assistance;
  - Individuals under the age of 21;
  - The spend-down population;
  - Individuals enrolled in partial benefit programs;
  - Individuals enrolled in the IL Breast and Cervical Cancer Program;
  - Individuals enrolled in Health Benefits for Workers with Disabilities
  - Individuals presumptively eligible;

- Individuals with comprehensive third-party insurance;
- Individuals incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution; and
- Individuals forensically committed to a State-operated psychiatric hospital.

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

- The following Medicaid services are included in the waiver:
  - Long-term Services and Supports provided under the Illinois Medicaid State Plan excluding ICF/MR services and including:
    - Nursing Facility Services
    - All services designed to assist individuals to live independently in the community, such as home health aides, adult day, and environmental adaptations, that are provided under the following IL Home and Community Based Waivers:
      - Persons who are Elderly;
      - Persons with Disabilities;
      - Persons with HIV/AIDS;
      - Persons with Brain Injury; and
      - Supportive Living Facilities Waiver.
  - Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option;
  - Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 120, 148.340 through 148.390, and 77 Ill. Admin. Code Part 2090; and
  - Transportation to secure Covered Services.

1. **Assurances.**

_X_ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

- The State assures that the service package provided under the waiver program for eligible waiver enrollees will be in the same amount, duration, and scope as available under the State Plan. Waiver enrollees will have access to all other State Plan services not covered under the waiver program through fee-for-service in the same amount, duration, and scope as required under the State Plan.
- The waiver does not include emergency services or family planning services. Enrollees will continue to receive emergency and family planning services via fee-for-service Medicaid.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

_X_ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.
- The State will comply with these requirements in so far as they are applicable to the waiver.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

_X_ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

- The waiver does not include emergency services. Enrollees will continue to receive emergency services via fee-for-service Medicaid or Medicare.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
___ Other (please explain):
_X_ Family planning services are not included under the waiver.

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
_X_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:
___The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program

- Under the waiver, FQHCs may provide behavioral health Covered Services. The State will guarantee all enrollees have a choice of at least one PIHP with a participating FQHC through the network adequacy component of the Readiness Review and future EQR audits after implementation.
  The waiver only includes FQHC behavioral health services that are covered by Medicaid and not Medicare. Enrollees will continue to receive other FQHC services via fee-for-service Medicaid/Medicare.

5. **EPSDT Requirements.**

_N/A_ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

- The waiver does not include EPSDT services.

6. **1915(b)(3) Services.**

___This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

_ **X** The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

- Enrollees will be able to self-refer to American Indian Health Services of Chicago for behavioral health services.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the

Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. ___ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):
4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

b. ___ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. ___ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

Capacity Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a.___ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b.___ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.

c.___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

d.___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1.			

*Please note any limitations to the data in the chart above here:

e.___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

f.___ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	***PCCM-to-Enrollee Ratio***
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___ **Other capacity standards** (please describe):

3. **<u>Details for 1915(b)(4) FFS selective contracting programs</u>:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

B. Coordination and Continuity of Care Standards

1. **Assurances For MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs**.

The following items are required.

a. _X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

- Based on the limited benefit package PIHPs are responsible for providing to waiver enrollees (primary care and specialist services are not covered services under the waiver) and that PIHPs are required to perform assessments, identify ongoing conditions, and develop treatment plans for all enrollees, the PIHP does not need to meet the requirements under 42 CFR 438.208.
- For all enrollees, PIHPs will be required to follow the process outlined below to identify risk-levels and ongoing special conditions that require care management:
    - Risk Stratification: The PIHP shall use population- and individual-based tools and real-time enrollee data, as available, to identify an enrollee's risk level and any special conditions including:
        - Health Risk Screening. The PIHP will make its best efforts to administer a health risk screening, which includes behavioral health risk, to all new enrollees within sixty days after enrollment. The PIHP may administer a health risk assessment in place of the health risk screening provided it is administered within sixty days after enrollment.
        - Predictive Modeling. The PIHP will utilize claims and Care Coordination Claims Database (CCCD) data to risk stratify the

population and to identify high risk conditions needing immediate care management.

- Surveillance Data. The PIHP will use predictive modeling to proactively identify high-risk enrollees and use other information gathered though avenues such as referrals, transition information, service authorizations, alerts, memos, results of the determination of needs assessment (DON), and from families, caregivers, Providers, community organizations and Contractor personnel to supplement the health risk screening and/or assessment.

- Stratification. Based upon an analysis of the information gathered as described above, the PIHP shall stratify all enrollees to the appropriate level of intervention. Enrollees shall be assigned to either low-, moderate-, or high-risk.
- Health Risk Assessment. The PIHP shall complete a face-to-face health risk assessment for all Enrollees, in the Enrollee's residence, within the 90-day transition period for new enrollees, the 90-day transition period for enrollees switching from another health plans or transitioning to nursing facilities, and within 15 days after the PIHP is notified that the enrollee is determined eligible for HCBS waiver services.
- Care Plans. The PIHP shall assign a care team, with a care coordinator, to all enrollees. The care team, in conjunction with the enrollee, will develop a comprehensive person-centered care plan, unless the enrollee refuses a care plan, within 90 days of enrollment for new enrollees. For enrollees switching from another plan to the PIHP or transitioning to nursing facilities, the care plan must be developed within 90 days after enrollment.

  For individuals deemed newly eligible for HCBS services, the HCBS service plan must be developed within 15 days after the PIHP is notified that the enrollee is determined eligible for HCBS waiver services. For enrollees receiving HCBS waiver services at the time of enrollment, the existing service plan will remain in effect for at least a 90-day transition period unless changed with the input and consent of the enrollee and only after completion of a face-to-face comprehensive health risk assessment in the enrollee's home.

  Care plans are inclusive of the HCBS service plan. The care plan will incorporate any ongoing conditions identified during the stratification process as well as an enrollee's medical, behavioral health, LTSS, social, and functional needs (including those functional needs identified on the DON or other assessment tool that is adopted by the State for HCBS waiver enrollees). It will also include identifiable short- and long-term treatment and service goals to address the enrollee's needs and preferences and to facilitate monitoring of the enrollee's progress and evolving service needs. PIHPs will be required to coordinate and provide referrals to ensure that an enrollee's care plan is holistic and person-centered.

b. ___ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

c. ___ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

d. ___ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2.__ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3.__ In accord with any applicable State quality assurance and utilization review standards.

e. ___ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. ___ Each enrollee is receives **health education/promotion** information. Please explain.

d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. ___ There is appropriate and confidential **exchange of information** among providers.

f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.

g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

i. ___ **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs**.

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

• Furthermore, the State assures compliance with 42 CFR Part 438 Subpart E, as these rules apply to the MLTSS PIHP scope of benefits.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

_X_ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

- An Illinois MCO quality strategy was submitted to the CMS Regional Office on 4/11/13. An updated quality strategy was submitted on April 20, 2017, and the 2016-2018 Quality Strategy was submitted to CMS June 29, 2018. The Department's current 2021-2024 Quality Strategy was submitted to CMS on March 10, 2021. The Department has discussed the 2024-2027 Quality Strategy submission with CMS. The Department's 2024-2027 Quality Strategy is projected to be submitted to CMS during the fourth quarter of CY2024.

_X_ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

		Activities Conducted

Program	Name of Organization	EQR study	Mandatory Activities	Optional Activities
PIHP	Health Services Advisory Group (HSAG)		1) Validation of Performance Improvement Projects 2) Validation of performance measures 3) Annual reviews, conducted within the previous 3-year period to determine the PIHP's compliance with standards established by the state to comply with 438.204 4) network adequacy validation activities*	1) validation of consumer or provider surveys of quality of care

Note: The contracted EQRO also performs the following: readiness reviews, network analyses, evaluation of State's Quality Strategy, technical assistance at State's request.
* The EQRO currently performs network adequacy activities, which will be modified, as needed, to comply with the mandatory network adequacy validation as described at 438.358(b)(iv).

2. **Assurances For PAHP program.**

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and

42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. ___ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1.___ Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3.___ Request PCCM's response to identified problems;

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7.___ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM

administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

    A. ___ Initial credentialing
    B. ___ Performance measures, including those obtained through the following (check all that apply):
        ___ The utilization management system.
        ___ The complaint and appeals system.
        ___ Enrollee surveys.
        ___ Other (Please describe).
4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. __ Other (please describe).

d. ___ **Other quality standards** (please describe):

4. **<u>Details for 1915(b)(4) only programs</u>:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

_X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**

a. **Scope of Marketing**

1.___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

2._X_ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

- With the exception of prohibited marketing activities specified in the contract, marketing by any medium, including mail, mass-media advertising, and community-oriented, and the content of all marketing materials, is allowed subject to the Department's prior approval.

3._X_ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

- With the exception of prohibited marketing activities specified in the MCO contract, marketing by any medium, including mail, mass-media advertising, and community-oriented, and the content of all marketing materials, is allowed subject to the Department's prior approval.

b. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1._X_ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

- PIHPs may not provide gifts or incentives to potential enrollees unless such gifts or incentives are also provided to the general public and do not exceed ten dollars in value per individual gift or incentive.
- PIHPs must submit all gifts provided to potential enrollees as part of its marketing plan for prior approval by the State.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3._X_ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):):

- The State requires PIHPs to translate marketing materials into Spanish because at least five percent of the waiver population speaks this language according to published Census data.

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii._X_ The languages comprise all languages in the service area spoken by approximately _5__ percent or more of the population.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

_X_ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details.**

a. **Non-English Languages**

_X_ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as:
(check any that apply):

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. _X_ The languages spoken by approximately _5_ percent or more of the potential enrollee/ enrollee population.
3.__ Other (please explain): Spanish

_X_ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

- PIHPs are required to operate a language line that makes oral interpretation services available free of charge in all languages to all potential enrollees or enrollees who need oral translation assistance. PIHPs must include in all key oral contacts and written materials notification that such oral interpretation

services are available and how to obtain such services. PIHPs shall conduct oral contacts with potential enrollees or enrollees in a language the potential enrollees and enrollees understand.

- In addition, PIHPs are required to hire staff from in and around the service area to ensure cultural competence. All PIHP staff receive training on all PIHP policies and procedures during new hire orientation and ongoing job-specific training to ensure effective communication with the diverse enrollee population, including translation assistance, assistance to the hearing impaired and those with limited English proficiency. PIHPs conduct targeted enrollee focus groups to obtain additional input on PIHP materials and program information and shall also seek input from local organizations that serve enrollees.

_X_ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

- The Client Enrollment Services (CES) provides counseling to potential enrollees and enrollees to help them understand the managed care program and their managed care options.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X_State
_X_contractor (please specify) Client Enrollment Services(CES) - Maximus

___ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) _X_ the State
(ii) _X_ State contractor (please specify): The CES will provide required information to potential enrollees.
(ii) _X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. _X_ **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

- For potential enrollees and enrollees, the CES sends out mailings including information guides about managed care options and enrollment packets.
- The State continues to provide updates to stakeholders and receive stakeholder feedback on the MMAI and the MLTSS waiver through MAC meetings.

b. **Administration of Enrollment Process**.

___ State staff conducts the enrollment process.

_X_ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

_X_ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Client Enrollment Services

Please list the functions that the contractor will perform:

___ choice counseling
___ enrollment
___ other (please describe):

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

__ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

_X_ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. _X_ Potential enrollees will have 30 days/~~month(s)~~ to choose a plan.
ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

- For MMAI eligible, at least 60 days prior to their passive enrollment into MMAI, beneficiaries will begin receiving enrollment letters informing the beneficiary of their managed care options including MMAI and the waiver. Thirty days prior to passive enrollment into MMAI, beneficiaries who have not voluntarily enrolled in MMAI or opted out of the MMAI will receive another letter informing them of the MCO to which they will be auto-assigned if they do not select another managed care option. The letter will inform the waiver eligible beneficiary that should they opt out of the MMAI and does not choose another managed care option available to them prior to their auto-assignment date, they will be auto-assigned to a PIHP (the same assignment as under the MMAI when the parent company participates in both programs) under the waiver.

ii. _X_ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

- Auto assignment is based on continuity of care and considers an enrollee's link to an existing waiver MCO, claims history, current LTSS providers, and geographic considerations. It currently follows chronologically the criteria listed below:
    - Long term care facility the client is currently admitted to, if applicable
    - Most recent prior enrollment to a PIHP under the waiver, if applicable;
    - Most recent prior enrollment to a health plan in the Integrated Care Program or Family Health Plan-Affordable Care Act Adult Program;
    - Geomapping using health plan band assignment.

  However, the State reserves the right to re-evaluate and modify the auto-assignment algorithm at any time and may provide that auto-assignment will be based on PIHPs' performance on quality measures.

___ The State **automatically enrolls** beneficiaries
- ___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
- ___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
- ___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

_X_ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

_X_ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i.___ Enrollee submits request to State.

ii._X_Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

* Enrollees may select another MCO during the initial 90-day enrollment change period and during the 60-day annual open enrollment period. These enrollees may disenroll at any time, for reasons with cause, and select another MCO. The State must approve for-cause disenrollment requests.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

___ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

_X_ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

- Causes for disenrollment include:
  - Administrative or data entry error in assigning an enrollee to a PIHP;
  - Enrollee moves out of the PIHP service area;
  - PIHP, due to its exercise of Right of Conscience pursuant to 745 ILCS 70/1, does not provide the Covered Service that the Enrollee seeks;
  - Enrollee needs related Covered Services that are not all available through PIHP to be performed at the same time, and the Enrollee's PCP or other Provider determines receiving the services separately would subject the Enrollee to unnecessary risk;
  - Enrollee is no longer eligible for LTSS as determined by the State, including death, other significant coverage or Spend-down status, and incarceration in a county jail;
  - Enrollee enrolls in the MMAI.

___ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

_X_ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

i._X_ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons: The enrollee moves out of the contracting area.

ii._X_ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii.___ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv._X_ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

_X_ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs**. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

_X_ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

_X_ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for MCO or PIHP programs**.

a. **Direct access to fair hearing**.

_X_ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

___ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. **Timeframes**

_X_ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days (between 20 and 90).

_X_ The State's timeframe within which an enrollee must file a **grievance** is n/a days. An enrollee may file a grievance at any time.

c. **Special Needs**

_X_ The State has special processes in place for persons with special needs. Please describe.

- PIHPs are required to provide assistance to enrollees in filing an internal appeal or in accessing the fair hearing process including assistance in completing forms and completing other procedural steps. This includes providing interpreter services, translation assistance, assistance to the hearing impaired (including toll-free numbers that have adequate TTY/TTD) and assisting those with limited English proficiency. The PIHP must make oral interpretation services available free of charge in all languages to all enrollees who need assistance.

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

___ The State has a grievance procedure for its ___ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:
- ___ the State
- ___ the State's contractor. Please identify: _____
- ___ the PCCM
- ___ the PAHP.

___ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

___ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff

composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

___ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

___ Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

___ Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process____

___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

___ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

_X_ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
    a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances For MCO or PIHP programs**

_X_ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

_X_ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation				X							X	X
Consumer Self-Report data				X	X	X	X		X	X	X	X
Data Analysis (non-claims)				X		X				X	X	X
Enrollee Hotlines		X	X	X	X	X	X		X	X	X	X
Focused Studies												
Geographic mapping												
Independent Assessment	X		X			X	X		X		X	X
Measure any Disparities by Racial or Ethnic Groups												X
Network Adequacy	X						X	X			X	

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Assurance by Plan												
Ombudsman		X	X	X	X	X	X		X	X	X	X
On-Site Review			X	X	X	X	X	X	X	X	X	X
Performance Improvement Projects												X
Performance Measures							X		X	X		X
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload										X		X
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review				X					X	X		X
Other: (describe)												

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Network Adequacy by State	X						X	X				
Quality Review by State				X		X		X	X			
State Prior Approval		X	X		X							
Quality Calls & Meetings												X

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ____ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

b. __X__ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

_X__ NCQA
___ JCAHO
___ AAAHC
_X__ Other (please describe)

- If PHIP is serving at least 5,000 seniors or people with disabilities, or 15,000 individuals in other populations covered by the Medicaid Program and has received full-risk capitation for at least one year, then PIHP is considered eligible for accreditation and shall achieve accreditation by the NCQA within two years after the date Contractor became eligible for accreditation. PIHP's failure to achieve accreditation may result in the termination of the contract.
- The State requires that if the managed care entity is organized as an HMO, it must obtain and maintain during the contract term a valid certificate of authority as an HMO under 215 ILCS 125/1-1, *et seq*., and provide proof of certificate of authority upon the department's request. If organized as a MCCN, for so long as the managed care entity meets the requirements of 89 Ill. Admin. Code Part 143, the entity may be deemed by the department to be a certified MCCN.
- The contracted MCOs providing MLTSS are required to authorize the NCQA to submit directly to HFS a copy of their final accreditation survey. On an annual

basis between accreditation surveys, MCOs must submit a copy of the accreditation summary report to HFS. HFS annually reviews MCOs' accreditation status and posts this status on the HFS care coordination webpage.

c. __X___ Consumer Self-Report data
- __ CAHPS (please identify which one(s))
- _X_ State-developed survey (Other)
- ___ Disenrollment survey
- ___ Consumer/beneficiary focus groups

- HealthChoice Illinois contracted MCOs complete an Adult CAHPS survey each year for their entire managed care enrollee population. In 2020, the EQRO conducted the Veterans RAND 12 Item Health Survey along with several questions from the CDC Behavioral Risk Factor Surveillance System Health Days Measures specifically for the MLTSS waiver population.

d. __X__ Data Analysis (non-claims)
- ___ Denials of referral requests
- ___ Disenrollment requests by enrollee
  - ___ From plan
  - ___ From PCP within plan
- _X_ Grievances and appeals data
- ___ PCP termination rates and reasons
- _X_ Other (please describe)

- PIHPs are required to submit quarterly reports summarizing all appeals filed by enrollees and the responses to and disposition of those matters (including decisions made following an external independent review), for the State to review. Non-claims reports routinely provided by the MCOs to HFS include: Fraud and Abuse, Community Outreach, Prior Authorization, HEDIS Measures, Executive Summary, Critical Incidents, Grievance and Appeals, Care Management & Disease Management Summary, Utilization Management, Call Center Statistics. Provider credentialing is conducted by HFS through its IMPACT system.

e. __X__ Enrollee Hotlines operated by State

- The State monitors enrollee issues through the Department of Healthcare and Family Services Health Benefit Hotline, the Department of Human Service Help Line, the Department on Aging's Senior Helpline and Senior Health Insurance Program (SHIP) hotline. Reports will be generated from the hotlines for monitoring and oversight.

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. ___ Geographic mapping of provider network

h. __X___ Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

- The State External Quality Review Organization (EQRO) conducts an independent evaluation of program impact, access, and quality and an actuarial firm will conduct an independent evaluation of the program's cost effectiveness.

i. __X__ Measurement of any disparities by racial or ethnic groups

- PIHP's are required to engage and utilize an Enrollee Advisory and Community Stakeholder Committee that provides feedback to the Quality Assurance Program (QAP) Committee on the MCO's performance from enrollee and community perspectives. The committee recommends program enhancements based on enrollee and community needs, reviews provider and enrollee satisfaction survey results, evaluates performance levels, evaluates access and provides feedback on issues requested by the QAP Committee, identifies key program issues such as disparities, that may impact community groups, and offers guidance on reviewing enrollee materials and effective approaches for reaching enrollees. The Committee is comprised of enrollees, family members and other caregivers, local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations.

j. __X__ Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

PIHPs are required to submit network analysis reports and updates to the EQRO for review. The EQRO does a thorough analysis by provider type and summarizes findings. The report is presented to the State and the PIHP to indicate and correct gaps in network prior to go live.

k. __X__ Ombudsman

- The Illinois Department on Aging maintains the Ombudsman program for Long Term Services and Supports. This program includes the Senior Helpline, which helps people learn about nursing homes and other long-term care settings. It also helps solve problems between these settings and the residents or their families. Another place for help is the Senior Health Insurance Program (SHIP) hotline, which gives free health insurance counseling to people with Medicare. The Illinois Department of Healthcare and Family Services runs the Illinois Health Benefits Hotline, which answers any questions regarding Medicaid benefits.

l. __X__ On-site review

- The EQRO completes a review at least once every three years to determine the extent to which the MCOs are in compliance with federal standards. The comprehensive compliance review by the EQRO includes, but is not limited to, the following areas:
  - Availability of Services
  - Assurances of adequate capacity and services
  - Coverage and authorization of services

- Provider selection
- Confidentiality
- Sub-contractual relationships and delegation
- Practice guidelines
- Quality assessment and performance improvement program
- Other federal and state requirements, as determined by the State
- Health information systems
- Grievances and appeals system

m. _X___ Performance Improvement projects [**Required** for MCO/PIHP]
_X_ Clinical
_X_ Non-clinical

- The PIHPs are required to participate in a collaborative performance improvement project chosen by both the State and the PIHPs. The topic will be determined based on where there is a need for improvement. The EQRO will provide technical assistance to ensure the Performance Improvement Project (PIP) is designed, conducted, and reported using sound methodology. The EQRO will also validate the PIP to determine the PIHPs compliance with measurement, implementation of interventions to achieve improvement, evaluate the effectiveness of the interventions, and planning activities for increasing and sustaining improvement over time. As PIPs are a continuous process, the MCOs receive annual training as needed technical assistance from the EQRO. HFS discusses PIPs with the MCOs on a routing basis to address initiatives and improvements.

n. __X__ Performance measures [**Required** for MCO/PIHP]
Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics

- HFS utilizes performance measures focusing on transition between programs, care coordination, person-centered care, staffing, network capability and access to services. Other areas of focus include reducing admissions to acute hospitals and long term care as well as lowering the readmission rate, retention of members in the community. The EQRO also conducts quarterly HCBS waiver reviews, which collect and report on HCBS waiver-specific CMS performance measures.

o. ___ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ____ Profile utilization by provider caseload (looking for outliers)

q. __ Provider Self-report data
__ Survey of providers

___ Focus groups

r. _____ Test 24 hours/7 days a week PCP availability

- Since PCP services are not included in the LTSS contract, the State will not complete this monitoring activity.

s. _X__ Utilization review (e.g. ER, non-authorized specialist requests)

- The contract requires MCOs to have a utilization review committee that implements the utilization review plan and process. This system of internal review includes medical, behavioral health, dental, waiver and long-term care services, medical evaluation studies, peer review, a system for evaluating the processes and outcomes of care, health education, systems for correcting deficiencies, and utilization review. MCOs' utilization review committees are assessed by the EQRO through the required compliance review every three years. HFS also receives annual information regarding utilization review via the MCOs' annual Quality Assessment/Utilization Review/Peer Review (QA/UR/PR) report.

t. __X__ Other: (please describe)

Network Adequacy by State – see discussion in section (j) above.
Quality Review by State – HFS conducts quarterly business reviews with each MCO to review performance metrics and discuss key policy, program, and operations issues.
HFS Prior Approval – The contract requires HFS Prior Approval (review and written approval) of various MCO materials, procedures, or actions.
Quality Calls & Meetings - HFS conducts quarterly quality meetings to discuss progress/outcomes, facilitate staff education, promote equity initiatives, and promote quality-related information specific to MCO performance. During these meetings, HFS and MCO staff discuss performance and quality improvement outcomes with a focus on the Quality Strategy goals and objectives. The meetings include representatives from the Managed Care Organization Quality Team, Bureau of Quality Management, Bureau of Managed Care, and other units who have a vested interest in the topic being discussed.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

X This is a renewal request.

__ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

X The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:

___ Yes
___ No. Please explain:

Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

RESULTS of MONITORING ACTIVITIES for the ORIGINAL WAIVER PERIOD from the INITIAL WAIVER RENEWAL (as provided in the 10/1/2019 renewal)

Strategy: (b) Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: All MLTSS contracted MCOs (PIHPs) participating in the MLTSS program achieved NCQA accreditation. Accreditation status is regularly monitored and updated. Accreditation status is publicly reported on the HFS Care Coordination website at https://www.illinois.gov/hfs/SiteCollectionDocuments/IL2018HFSWebsiteNCQAAccreditationDoc052218.pdf.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (c) Consumer Self-Report data
Conducted as described: ____Yes __X__No - Please describe: In 2016 and 2017, the Adult CAHPS survey was completed for the FHP-ACA and ICP populations but was not completed for enrollees in the MLTSS managed care program. Since 2018, HealthChoice Illinois MCOs conduct an annual Adult CAHPS survey that is inclusive of the total Medicaid managed care population, which includes the MLTSS waiver enrollees; however, the results are not stratified by population.
Summary of Results: None
Problems Identified: The Adult CAHPS has not been conducted specifically for MLTSS waiver enrollees. Given the survey's focus on medical conditions and services, it does not provide value-added information for the MLTSS population and does not address the MLTSS waiver service package.
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: HFS has identified a quality of life survey (the Veterans RAND 12 Item Health Survey (VR-12) and several questions from the CDC Behavioral Risk Factor Surveillance System Health Days Measures). HFS's EQRO will conduct this survey specifically for the MLTSS waiver population beginning in 2020.

Strategy: (d) Data Analysis (non-claims)
Conducted as described: __X__Yes __X__No - Please describe: Beginning 2018, MCO reported data to the Department was not stratified by population. However, the Department's EQRO analyzed MCO self-reported data for the MLTSS waiver population for the period July 2018 – June 2019.
Summary of Results: Prior to 2018 MLTSS waiver MCOs reported MLTSS-specific data related to grievances and appeals. The Department's review process included sending the reports to the Department's designated staff person within the Division of Medical Programs who reviewed the grievance and appeal reports for the Department's managed care programs. The Department's reviewer elevated concerns to the Account Manager of the MCO, if needed, for a higher level conversation between the Department and MCO. Through this review process, the Department determined that the existing reports restricted Department's ability to review trends and create comparisons across MCOs because MCOs were interpreting the instructions and data definitions differently. As a result, the Department revamped its managed care reporting process under the HealthChoice Illinois contract, beginning in 2018. The new MCO performance reporting process includes extensive data definitions that

allow for conversations on performance instead of data definitions as well as the ability to compare results across MCOs. The Department's EQRO analyzed MCO self-reported data for the MLTSS waiver population for the period July 2018 through June 2019. Analysis of grievance data identified that transportation grievances constituted the highest number of grievances for all MCOs, which was expected due to the MLTSS benefit package as well as in comparison to the MCOs overall Medicaid grievances. The EQRO's analysis identified that all MCOs were compliant with grievance response times and did not have recommendations related to the MCOs' grievance processes. The EQRO's analysis of appeals data revealed that the MCOs received very few MLTSS-related appeals since the implementation of the waiver; the EQRO did not have any recommendations related to the MCOs' appeal processes.
Problems Identified: As mentioned, data has not been stratified for the MLTSS waiver population since 2018.
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: Effective no later than the first quarter of 2020, HFS will revise the HealthChoice Illinois grievance and appeal reporting protocol to require specific reporting for the MLTSS waiver population.

Strategy: (e) Enrollee Hotlines operated by State
Conducted as described: ____Yes __X__No - Please describe: Hotline-specific reports are not generated; but complaints reported through hotlines are included in a comprehensive complaint report.
Summary of Results: HFS documents enrollee issues and complaints that are reported through the various State hotlines, as well as from other sources, such as the Client Enrollment Broker and calls made directly to HFS by elected officials. Issues are monitored by designated staff until resolved. Issues identified as time-sensitive and/or critical are promptly elevated and addressed by designated personnel. HFS has a close working relationship, that includes a standing monthly meeting, with the Department on Aging's Ombudsman and SHIP offices. Enrollee issues are discussed on this monthly call, but any concerns that require immediate or prompt resolution are elevated to liaisons within HFS who resolve eligibility, service authorization, service provision, etc. concerns. Historically, the volume of hotline calls has been low, and because issues are addressed as they arise, hotline-specific reports have not been needed.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (g) Geographic Mapping of Provider Network
Conducted as described: ____Yes _X_No - Please describe: Initially, MCOs developed the geo-mapped information and provided to HFS. HFS determined that the information in geo-map format was not beneficial and was difficult to analyze. The method to monitor, validate, and remediate MCOs' networks transitioned to the EQRO's network adequacy validation processes.
Summary of Results: None
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: This quality monitoring activity is being deleted for the requested MLTSS waiver renewal period. The managed care contract will be amended to reflect current practice.

Strategy: (h) Independent Assessment of Program
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: The Independent Assessment is accompanying this MLTSS Waiver renewal request.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (i) Measurement of any Disparities by Racial or Ethnic Groups
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: MCOs are contractually required to conduct annual cultural competency training of all MCO staff members, as well as provision of translation services and alternative formats to ensure effective communication with Waiver members. The MCOs conduct an annual CLAS analysis for their Medicaid population, which includes MLTSS-specific information related to enrollment and demographic composition of the population. The MCOs did not identify any MLTSS-specific disparities. The MCOs used the annual analyses to identify opportunities related to program enhancements, including care coordination and provider networking.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (j) Network Adequacy Assurance Submitted by Plan
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: For 2016 and 2017, the EQRO completed network readiness reviews of the MLTSS provider network prior to enrollment in July of 2016 and September of 2016. Following readiness review, the EQRO continued monitoring the MLTSS network quarterly until December of 2017. During statewide Medicaid managed care expansion, the MLTSS provider network was included in the HealthChoice provider network readiness review. Network review for statewide expansion included monthly analysis from October 2017 through July 2018. For MLTSS statewide expansion on July 1, 2019 the EQRO conducted analysis of the MLTSS utilization data in May of 2019. MCOs were required to target contracting efforts with MLTSS providers identified as not yet having a contract as a result of the utilization analysis. The EQRO continues to monitor contracting efforts for non-contracted providers quarterly.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (k) Ombudsman
Conducted as described: __X__Yes ____No - Please describe:
Summary *of Results:* HFS has a collaborative relationship with the Ombudsman office, that includes a standing monthly meeting. Enrollee issues are discussed on this monthly call, but any concerns that require immediate or prompt resolution are elevated to liaisons within HFS who resolve eligibility, service authorization, service provision, etc. concerns.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (l) On-Site Review

Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: The EQRO conducted a compliance readiness review prior to implementation of the MLTSS waiver in 2016, and again in 2017 prior to transition to the HealthChoice Illinois Medicaid managed care program. The EQRO also conducted an MLTSS readiness review prior to the July 1, 2019 statewide expansion. The EQRO is currently conducting administrative compliance reviews of all MCOs that includes MLTSS waiver-specific file sampling, which are scheduled to be completed by the end of calendar year 2019.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (m) Performance Improvement Projects

Conducted as described: ____Yes __X__No - Please describe: An MLTSS waiver-specific PIP has not been conducted because of the need to establish baseline data to determine the most-needed and appropriate PIP. Baseline data was not forthcoming due to the changes in the Medicaid managed care program and lack of encounter data. The MLTSS waiver began July 1, 2016, and the State determined late 2016/early 2017 that the Medicaid managed care programs would be consolidated into a single program and competitively procured. HCBS waiver encounter data has been highly problematic since the inception of the State's managed care programs (although HFS expects that the ongoing issues with the HCBS waiver encounter data will be resolved in 2020). Furthermore, to date, MLTSS waiver enrollee quality of life surveys have not yet been conducted. MCOs have conducted PIPs for their overall Medicaid population, but the information is not stratified by population.
Summary of Results: None
Problems Identified: As described above.
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: In anticipation of "clean" HCBS waiver encounter data, and survey results specific to MLTSS waiver enrollees, HFS intends to identify and implement a PIP designed for the MLTSS Waiver population in 2020

Strategy: (n) Performance Measures

Conducted as described: ____Yes _X_No - Please describe: HFS collects data on performance measures focusing on transition between programs, care coordination, person-centered care, staffing, network capability and access to services. HFS is identifying opportunities to measure and analyze data related to reducing admissions to acute care hospitals and long-term care as well as lowering the readmission rate. HFS has identified that the use of the CAHPS instrument is not well-suited to the MLTSS population and has identified an independent quality of life survey which will be conducted beginning January 2020.
Summary of Results: Specific to the MLTSS waiver, during 2017, the MLTSS waiver MCOs were required to report to HFS data on three care management-related performance measures: MLTSS 2.2 – Moderate and high-risk members with a health risk assessment completed within required time frames, MLTSS 3.2 – Members with documented discussion of person-centered care goals, and MLTSS 3.6 – Movement of members within long-term care.
Problems Identified: In addition to the discussion above, beginning 2018, all but one performance measure was not stratified by population.
Plan/Provider Level Corrective Action: N/A

System-wide Program Change: Effective no later than the first quarter of 2020, performance measure reporting protocol will require specific reporting for the MLTSS waiver population.

Strategy: (o) Periodic Comparison of Number & Types of Medicaid Providers Before/After Waiver

Conducted as described: ____Yes __X__No - Please describe: This activity was not conducted.
Summary of Results: None
Problems Identified: N/A
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: This quality monitoring activity is being removed as a required activity for the requested MLTSS Waiver renewal period.

Strategy: (q) Provider Self Report Data

Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: MCOs have traditionally conducted provider satisfaction surveys for their entire managed care enrollee population, the results of which are reported in their annual report along with identified opportunities for improvement to address specific needs. In addition, given the importance of providers having an outlet for reporting unresolved issues they have with a Medicaid MCO, HFS created a Managed Care Complaint Portal that launched in November 2016 to a limited set of physicians and hospitals and then became available to all provider types in January 2017. Providers submit complaints to HFS through the portal; HFS facilitates prompt and fair resolution of disputes. The portal has been a success and is appreciated by providers as an avenue to involve HFS. The portal can be found through the following link:
https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/ManagedCareComplaints.aspx
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: This quality monitoring activity is being removed as a required activity for the requested MLTSS Waiver renewal period.

Strategy: (s) Utilization Review

Conducted as described: _X_Yes ____No - Please describe:
Summary of Results: During 2017, MCOs reported MLTSS-specific data related to prior authorizations. All MCOs reported approval percentages of 90 percent or greater. The EQRO analyzed MCO self-reported denial data for the MLTSS population for the period July 2018 through June 2019 during the EQRO's 2019 compliance reviews and did not identify any areas of concern related to the MCOs' processes for utilization management of the MLTSS waiver population.
In addition to prior authorization data, the MCOs reported behavioral health and HCBS-specific utilization data in their annual QA/UR/PR reports, which included the top five diagnoses for behavioral health and the top five HCBS services utilized. The annual QA/UR/PR reports include MCO descriptions of care coordination for the HCBS population, as well as behavioral-health specific initiatives.
Problems Identified: After the transition to HealthChoice, MCOs began reporting overall Medicaid data which included monthly behavioral health data.
Plan/Provider Level Corrective Action: N/A

System-wide Program Change: HFS will implement MLTSS Waiver population-specific reporting for utilization statistics no later than the first quarter of 2020.

RESULTS of MONITORING ACTIVITIES for the FIRST WAIVER RENEWAL PERIOD of 1/1/2020 through 12/31/2024

Strategy: (b) Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: All contracted MCOs achieved NCQA accreditation. Accreditation status is regularly monitored and updated. Accreditation status was updated on the HFS Care Coordination website in February 2024 at:
il2024hfsncqaaccreditation.pdf (illinois.gov)
Problems Identified: The Department did not annually update accreditation status on the website in CY2022 and CY2023.
Plan/Provider Level Corrective Action: Department has corrected internal process to ensure annual posting.
System-wide Program Change: None

Strategy: (c) Consumer Self-Report data
Conducted as described: _ X ___Yes ____No - Please describe: Since 2018, HealthChoice Illinois MCOs conduct an annual Adult CAHPS survey that is inclusive of the total Medicaid managed care population, which includes the MLTSS waiver enrollees; however, the results are not stratified by population. HFS identified a quality of life survey (the Veterans RAND 12 Item Health Survey (VR-12) and several questions from the CDC Behavioral Risk Factor Surveillance System Health Days Measures), which was conducted by HFS's EQRO for the MLTSS waiver population in 2020.
Summary of Results: The quality of life survey was conducted in 2020, which presented statewide and MCO-specific results. HFS has directed its EQRO to administer the HCBS CAHPS survey beginning 2025.
Problems Identified: The Adult CAHPS has not been conducted specifically for MLTSS waiver enrollees. Given the survey's focus on medical conditions and services, it does not provide value-added information for the MLTSS population and does not address the MLTSS waiver service package.
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (d) Data Analysis (non-claims)
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: Non-claims reports collected by HFS that provide MLTSS population specific data elements include: enrollee grievances and appeals; new enrollee health risk screening and assessment; enrollee engagement risk stratification; provider disputes and grievances; and enrollee engagement including IPOC. These reports were implemented in the first quarter of CY2021 and are still being refined for data integrity.
Non-claims reports collected by HFS that include MLTSS in the total program population data elements (reports are not broken down into population specific details): Quarterly Business Review MCO Executive Summary; fraud and abuse; community outreach events; outreach summary; prior authorization; call center statistics; and HFS provider credentialing.

In the Department's Managed Care Organization Performance Reporting System (MPR), the MCOs began reporting on prior authorization metrics for MLTSS as of Q2 2021 (April – June 2021). The metrics are reviewed quarterly as part of the HFS and MCO MPR Quarterly Business Review process.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (e) Enrollee Hotlines operated by State
Conducted as described: ____Yes __X__No - Please describe: Hotline-specific reports are not generated; but complaints reported through hotlines are included in a comprehensive complaint report.
Summary of Results: HFS documents enrollee issues and complaints that are reported through the various State hotlines, as well as from other sources, such as the Client Enrollment Broker and calls made directly to HFS by elected officials. Issues are monitored by designated staff until resolved. Issues identified as time-sensitive and/or critical are promptly elevated and addressed by designated personnel. HFS has a close working relationship, that includes a standing monthly meeting, with the Department on Aging's Ombudsman and SHIP offices. Enrollee issues are discussed on this monthly call, but any concerns that require immediate or prompt resolution are elevated to liaisons within HFS who resolve eligibility, service authorization, service provision, etc. concerns. Historically, the volume of hotline calls has been low, and because issues are addressed as they arise, hotline-specific reports have not been needed.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (g) Geographic Mapping of Provider Network
Conducted as described: __ X __Yes __No - Please describe:
Summary of Results: MCOs are required to submit to the EQRO a quarterly provider file layout (PFL) that includes a range of provider types, including pediatric. The EQRO utilizes the provider network data submissions for network validation analysis and monitors health plan compliance with network adequacy requirements. All MCOs submitted quarterly data in CY2021, CY2022, and CY2023. Analyses of the PFL submissions did not identify any deficiencies that would indicate an adverse impact on access to care for the MLTSS population.
In addition, the EQRO completes an annual time and distance study. Results of the time and distance studies identified that overall, the health plans contracted with a broad network of providers with offices that are located reasonably close to the enrollees they serve, with 99 percent to 100 percent of enrollees showing providers located within the time and distance standards from their residences.
Beginning in 2024, the EQRO will also complete an annual network adequacy validation activity to comply with CMS' EQR Protocol 4: Validation of Network Adequacy, which was released by CMS in February 2023. All health plans serving MLTSS waiver enrollees will be included in this activity.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (h) Independent Assessment of Program
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: The Independent Assessment is accompanying this MLTSS Waiver renewal request.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (i) Measurement of any Disparities by Racial or Ethnic Groups
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: MCOs are contractually required to conduct annual cultural competency training of all MCO staff members, as well as provision of translation services and alternative formats to ensure effective communication with Waiver members. The MCOs conduct an annual CLAS analysis for their Medicaid population, which includes MLTSS-specific information related to enrollment and demographic composition of the population. The MCOs did not identify any MLTSS-specific disparities. The MCOs used the annual analyses to identify opportunities related to program enhancements, including care coordination and provider networking.
The MCOs have engaged and utilized their Enrollee Advisory and Community Stakeholder meetings to provide feedback to their QAP Committee. The committees have improved quality by listening to their providers and enrollees, reviewing performance levels, evaluating access and offering advice on enrollee materials and ways to locate and reach members. Since CY2021, HFS has required MCOs to report both HEDIS and various outcome measures by specific geographies, race, and gender in order to identify, evaluate, and reduce, to the extent possible, disparities. The MCOs report HEDIS and custom quality measures directly to the EQRO; the EQRO provides the performance measure data to HFS. HFS holds MCOs accountable to develop specific action plans to address the findings for specific populations. HFS is committed to the delivery of equitable access of its programs and services removing disparate impact on its customers, including MLTSS, by ensuring each population gets what they need to thrive. HFS will work with service providers, vendors, and contractors to institute approaches that prioritize equity and remove conditions and barriers to achieve optimal outcomes for customers. HFS further commits to engaging with customers who will have input in decision-making and opportunities to assist in advancing racial equity. HFS is committed to making equity the foundation of everything it does.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: HFS contractually mandates HCI MCOs employ an Equity Director. The Equity Directors are responsible for the strategic design, implementation, and evaluation of health equity efforts, plan practices related to disparity reductions, including the provision of health equity and social determinants of health, and ensuring the plan collects and meaningfully uses race, ethnicity, and language data to identify and reduce disparities.

Strategy: (j) Network Adequacy Assurance Submitted by Plan
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: MCOs are required to submit to the EQRO a quarterly provider file layout (PFL) that includes a range of provider types, including pediatric. The EQRO utilizes

the provider network data submissions for network validation analysis and monitors health plan compliance with network adequacy requirements. All MCOs submitted quarterly data in CY2021, CY2022, and CY2023. Analyses of the PFL submissions did not identify any deficiencies that would indicate an adverse impact on access to care for the MLTSS population.
In addition, the EQRO completes an annual time and distance study. Results of the time and distance studies identified that overall, the health plans contracted with a broad network of providers with offices that are located reasonably close to the enrollees they serve, with 99 percent to 100 percent of enrollees showing providers located within the time and distance standards from their residences.
Beginning in 2024, the EQRO will also complete an annual network adequacy validation activity to comply with CMS' EQR Protocol 4: Validation of Network Adequacy, which was released by CMS in February 2023. All health plans serving MLTSS waiver enrollees will be included in this activity.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (k) Ombudsman
Conducted as described: __X__Yes ____No - Please describe:
Summary *of Results:* HFS has a collaborative relationship with the Ombudsman office, that includes a standing monthly meeting. Enrollee issues are discussed on this monthly call, but any concerns that require immediate or prompt resolution are elevated to liaisons within HFS who resolve eligibility, service authorization, service provision, etc. concerns.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (l) On-Site Review
Conducted as described: __X__Yes ____No - Please describe:
Summary of Results: The EQRO conducted a compliance readiness review prior to implementation of the MLTSS waiver in 2016, and again in 2017 prior to transition to the HealthChoice Illinois Medicaid managed care program. The EQRO also conducted an MLTSS readiness review prior to the July 1, 2019 statewide expansion. In addition, the EQRO conducted a compliance review in CY2020, CY2022, and CY2023. Any deficiencies identified as a result of the compliance review are required to be remediated by the MCOs.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (m) Performance Improvement Projects
Conducted as described: _X___Yes ____No - Please describe: In 2022, HFS selected a new nonclinical PIP topic for the MCOs to complete for the MLTSS population: *Improving Transportation Services*. The PIP focused on the administration of the transportation benefit, specifically focusing on the rate of scheduled trips resulting in the enrollee arriving to a scheduled appointment on time. The MCOs submitted Steps 1 through 6 (selection of the topic, defining the Aim statement, defining the population, sampling methodology, defining the performance indicator[s], and defining the data collection process) without baseline data. In

2023, the MCOs reported baseline data. All PIPs were found to be methodologically sound and all MCOs received 100 percent validation scores for the MLTSS reported population. The PIP is scheduled to continue through 2025.
Summary of Results: None
Problems Identified: As described above.
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Strategy: (n) Performance Measures
Conducted as described: ____Yes _X_No - Please describe: HFS collects data on performance measures focusing on transition between programs, care coordination, person-centered care, staffing, network capability and access to services. HFS is identifying opportunities to measure and analyze data related to reducing admissions to acute care hospitals and long-term care as well as lowering the readmission rate. HFS has identified that the use of the CAHPS instrument is not well-suited to the MLTSS population and has identified an independent quality of life survey which will be conducted beginning January 2020.
Summary of Results: Specific to the MLTSS waiver, during 2017, the MLTSS waiver MCOs were required to report to HFS data on three care management-related performance measures: MLTSS 2.2 – Moderate and high-risk members with a health risk assessment completed within required time frames, MLTSS 3.2 – Members with documented discussion of person-centered care goals, and MLTSS 3.6 – Movement of members within long-term care.
Problems Identified: In addition to the discussion above, beginning 2018, all but one performance measure was not stratified by population.
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: Effective no later than the first quarter of 2020, performance measure reporting protocol will require specific reporting for the MLTSS waiver population.

Strategy: (s) Utilization Review
Conducted as described: _X_Yes ____No - Please describe:
Summary of Results: All MCOs routinely report on utilization review. In the MPR, the MCOs began reporting on prior authorization metrics for MLTSS as of Q2 2021 (April – June 2021). The metrics are reviewed quarterly as part of the HFS and MCO MPR Quarterly Business Review process.
In addition to prior authorization data, the MCOs reported behavioral health and HCBS-specific utilization data in their annual QA/UR/PR reports, which included the top five diagnoses for behavioral health and the top five HCBS services utilized. The annual QA/UR/PR reports include MCO descriptions of care coordination for the HCBS population, as well as behavioral-health specific initiatives.
Problems Identified: None
Plan/Provider Level Corrective Action: N/A
System-wide Program Change: None

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost

Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: Dan Jenkins

c. Telephone Number: (217) 524-7400

d. E-mail: Dan.Jenkins@illinois.gov

e. The State is choosing to report waiver expenditures based on

X date of payment.

__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a.___ MCO
b. X PIHP
c.___ PAHP
d.___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  1.___ First Year: $____ per member per month fee
  2.___ Second Year: $____ per member per month fee
  3.___ Third Year: $____ per member per month fee
  4.___ Fourth Year: $____ per member per month fee

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data
  1.___ Base year data is from the same population as to be included in the waiver.
  2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

_____

d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

_____

For Conversion or Renewal Waivers:

a. X [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c. X [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
For P1 through P5, approximately 2.4% annual growth was assumed from July 2024 enrollment. The estimated enrollment growth was based upon dual-eligible LTSS capitated member month growth in the Medicare-Medicaid Alignment Initiative (MMAI) and MLTSS programs combined between January 2021 and July 2024.

d. __ [Required] Explain any other variance in eligible member months from BY/R1 to P2:

e. X [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: Calendar year (CY).

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a. X [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:
The historic periods reflect fee-for-service transportation costs, and those costs have been removed in cell J13 of the tab [D5. Waiver Cost Projection]. The transportation costs were carved out of the capitation rates in the previous 5-year waiver period. The MCOs do not administer the carved-out transportation benefit, so the service is excluded from this waiver renewal. This waiver renewal reflects all services covered under the capitation rates.

b. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account:
All services for which the MCOs are not responsible have been excluded from this analysis. Participants in five 1915(c) waivers who are dual-eligibles may enroll in this 1915(b) waiver program. The cost of the 1915(c) waiver services is included within the capitation rates for this program.

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart

below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

The allocation method for either initial or renewal waivers is explained below:

a. X The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c.___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

a.___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services	*$1,751,500 or $.97 PMPM R1*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1*

financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,959,150 or $1.04 PMPM R2 or BY in Conversion*		*$2,291,216 or 1.10 PMPM in P2*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b. X The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations: The Actual Waiver Costs reflect historical costs under this 1915(b) waiver. These historical costs reflect selection bias, if any, experienced in the historical periods.

c.___ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d. X Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:
The State withheld 2% of the capitation rate that MCOs received in R1 and R2. MCOs were paid the withheld amounts based upon their performance on quality measures.

1. X [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.
   i. Document the criteria for awarding the incentive payments.
   HFS awarded withheld amounts based on MCO performance on quality measures.
   ii. Document the method for calculating incentives/bonuses, and
   HFS attributed a portion of the withheld amounts to performance on each quality measure in relation to targets. Unearned withheld amounts were distributed to the MCOs based upon their quality performance, as required by Illinois state law.
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.
   HFS is finalizing its process to monitor PMPM spending quarterly to ensure that payments to MCOs including any incentive payments do not exceed the Waiver Cost Projection.

2. ____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**
   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses, and
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. X [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is:

MEG	R2 to P1
Blended LTSS	11.0%

Please document how that trend was calculated:
Annual trends from R2 (CY 2023) to P1 (CY 2025) are generally consistent with the trend development that will be documented in the CY 2025 HealthChoice Illinois rate certification, which is currently in draft. Linear regression, Medicaid benchmark trends, and actuarial judgment to select the final trend rates was applied. Trends were developed by service category

and the values in this projection represent the composite trend across all service categories.

2. X [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. X State historical cost increases. Please indicate the years on which the rates are based: January 2019 through December 2024. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

MEG	P1 to P5 (Annualized)
Blended LTSS	9.5%

Trends between P1 to P5 are consistent with the annual trends between R2 to P1 for the State Plan service trends and program adjustment trends in composite. This was done in recognition that it is not yet known the program changes that will occur between P1 and P5 but assume that they are generally consistent between R2 to P1 and P1 to P5. However, as the program changes are not known as of the writing of this waiver renewal, they were combined into the State Plan inflation adjustment for purposes of trending P1 to P5.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. X An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi.__ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____X Other (please describe):

Adjustments have been made for programmatic or legislative changes occurring after the end of the R2 period (December 31, 2023). These programmatic and legislative changes will be documented in the CY 2025 HealthChoice Illinois rate certification. The majority of these program changes can be characterized as fee schedule adjustments, which included material fee schedule increases for nursing facility and HCBS waiver services.

c.___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2. X An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii.___ Cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C. X State Historical State Administrative Inflation. The actual trend rate used is: 4.1%. Please document how that trend was calculated: Annual cost increases were estimated based on the average change in CPI-U over the five years August 2019 through August 2024.

D.____ Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present)*. The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**.

_____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.

- ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 – Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:
   For P1 through P5, approximately 2.4% annual growth from July 2024 enrollment was assumed. The estimated enrollment growth was based upon dual-eligible LTSS capitated member month growth in the MMAI and MLTSS programs combined between January 2021 and July 2024.
2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:
   Adjustments have been made for programmatic or legislative changes occurring after the end of the R2 period (December 31, 2023). These programmatic and legislative changes will be documented in the CY 2025 HealthChoice Illinois rate certification. The majority of these program changes can be characterized as fee schedule adjustments, which included material fee schedule increases for nursing facility and waiver services.
3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:
   Annual trends from R2 (CY 2023) to P1 (CY 2025) are generally consistent with the development of draft managed care capitation rates expected to be effective during CY 2025. We do not expect trends to materially change in final capitation rate development. Linear regression, Medicaid benchmark trends, and actuarial judgment were applied to select the final trend rates. Trend assumptions are generally intended to account for utilization trends in the capitation rate development. Trends were developed by service category and the values in this projection represent the composite trend across all service categories.
   Trends between P1 to P5 are consistent with the annual trends between R2 to P1 for the State Plan service trends and program adjustment trends in composite. This was done in recognition that it is not yet known the program changes that will occur between P1 and P5 but assume that they are generally consistent between R2 to P1 and P1 to P5. However, as the program changes are not known as of the writing of this report, they were combined into the State Plan trend adjustment for purposes of trending each year from P1 to P5.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.