



**OPEN MINDS**

# Illinois Health & Human Services Market Profile



# Illinois Health & Human Services Market Profile Overview

## A. [Executive Summary](#)

1. Health Care Coverage by Payer
2. Medicaid Care Coordination Initiatives
3. Behavioral Health Safety-Net System Overview

## B. [Health Financing System Overview](#)

1. Population Demographics
2. Population Centers
3. Population Distribution By Payer
4. Largest Health Plans
5. Health Insurance Marketplace
6. Accountable Care Organizations

## C. [Medicaid Administration, Governance & Operations](#)

1. Medicaid Governance
2. Medicaid Program Spending
3. Medicaid Expansion Status
4. Medicaid Program Benefits

## D. [Medicaid Financing & Service Delivery System](#)

1. Medicaid Financing & Service Delivery System
2. Medicaid FFS Program
3. Medicaid Managed Care Program
4. Medicaid Program: Care Coordination Initiatives
5. Medicaid Program Waivers
6. Medicaid Program: New Initiatives

## E. [Dual Eligible Financing & Service Delivery System](#)

1. Dual Eligible Medicaid Financing & Service Delivery System
2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment
3. Dual Eligible Medicaid Financing & Delivery System: Overview
4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

## F. [Long-Term Services & Supports System](#)

1. LTSS Financing & Service Delivery System
2. LTSS Medicaid Financing & Delivery System: Overview
3. LTSS Health Plan Characteristics
4. LTSS Program Benefits
5. LTSS Medicaid Financing & Delivery System: New Initiatives

## G. [State Behavioral Health Administration & Finance System](#)

1. Public Behavioral Health System Governance
2. Public Behavioral Health System Spending
3. State Psychiatric Institutions
4. Behavioral Health Safety-Net Delivery System

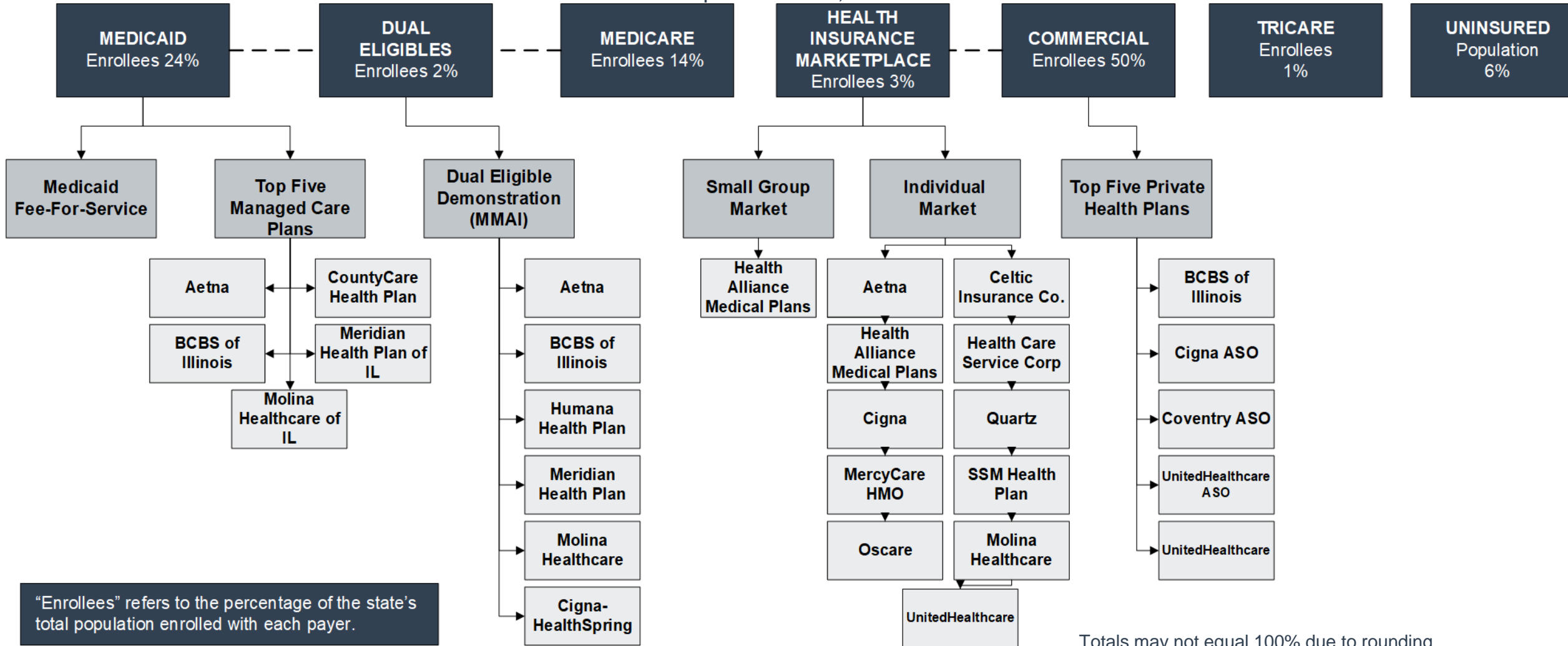
## H. [Appendices](#)

1. *OPEN MINDS* Estimates For The Share Of SMI Consumers By Payer/Plan
2. Glossary Of Terms
3. Sources

# A. Executive Summary

# A.1. Illinois Physical Health Care Coverage by Payer

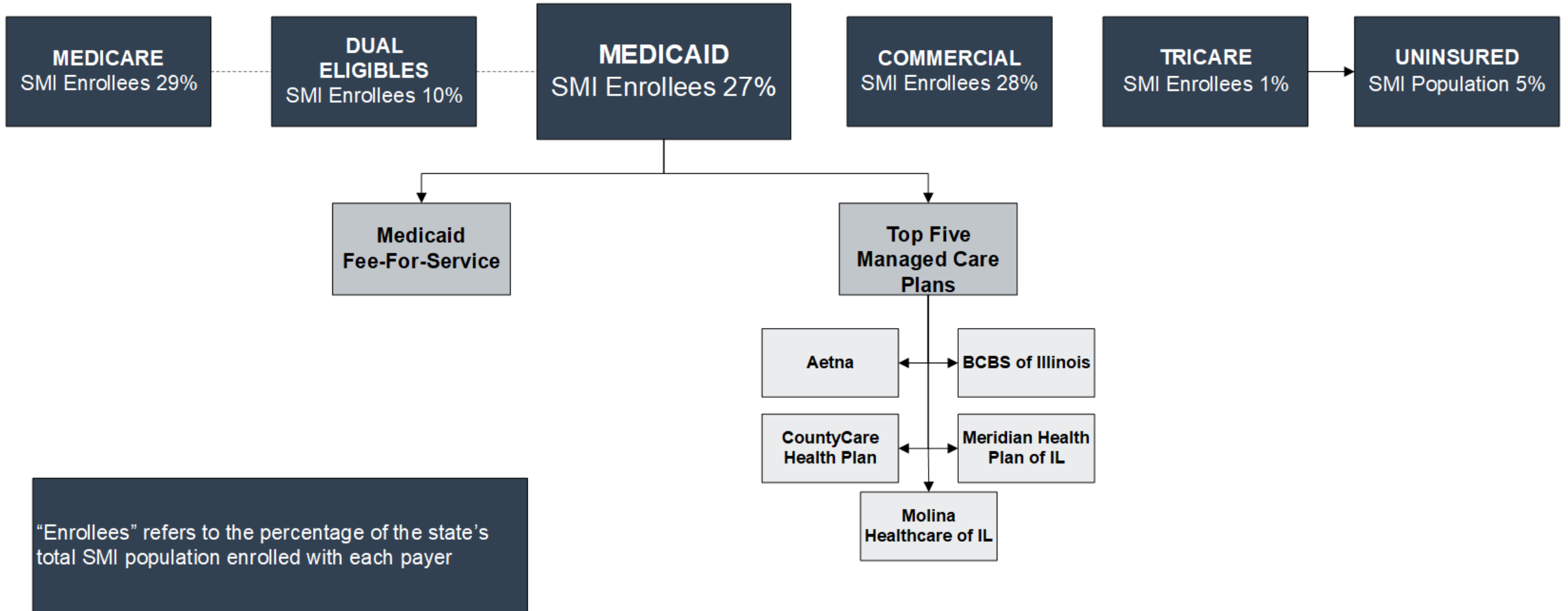
Total Illinois Population- 12,671,469  
 Estimated SMI Population- 922,350



“Enrollees” refers to the percentage of the state’s total population enrolled with each payer.

Totals may not equal 100% due to rounding

# A.1. Illinois Behavioral Health Care Coverage by Payer



“Enrollees” refers to the percentage of the state’s total SMI population enrolled with each payer

Totals may not equal 100% due to rounding

## A.2. Health & Human Services Care Coordination Initiatives

Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Medicaid health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		Illinois discontinued its PCCM program in December 2017.
Accountable Care Organization (ACO) Program		Illinois transitioned its Medicaid ACO enrollees to full-risk managed care in 2016.
Affordable Care Act Model Health Home	✓	The state had delayed implementation of the health home program as it reviews the model and is currently rescinding approved SPA's.
Patient-Centered Medical Home (PCMH)		None.
Dual Eligible Demonstration	✓	The state has a dual demonstration which extends until December 2023.
Managed Long-Term Services and Supports (MLTSS)	✓	Health plans are responsible for providing LTSS to the managed care population and dual eligibles requiring LTSS.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Illinois operates nine CCBHCs under federal funding.

## A.3. Health Care Safety-Net Delivery System

### State Agencies Responsible For Uninsured Citizens & Delivery System Model

#### Physical Health Services

- The Illinois Department of Public Health administers grants to supplement local funding of county or multi-county health departments that provide physical health services for the safety-net population.

#### Mental Health Services

- The Illinois Department of Human Services (DHS) Division of Mental Health (DMH) contracts with a network of community mental health centers and agencies to provide mental health services to the safety-net population.
- The Illinois Mental Health Collaborative operated by Beacon Health Options is the administrative services organization for safety-net services. Beacon provides utilization management, provider organization contracting, and data reporting.

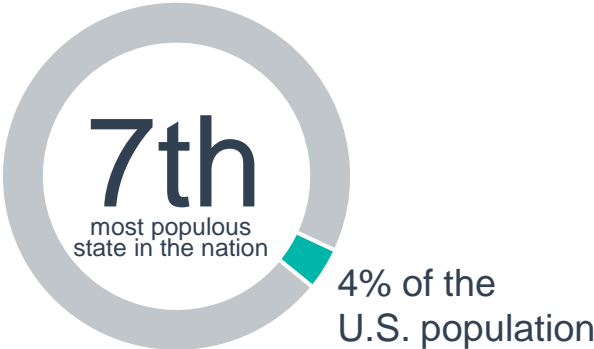
#### Addiction Treatment Services

- Within DHS, the Division of Alcoholism and Substance Abuse (DASA) contracts with community-based organizations to maintain a statewide addiction treatment program.

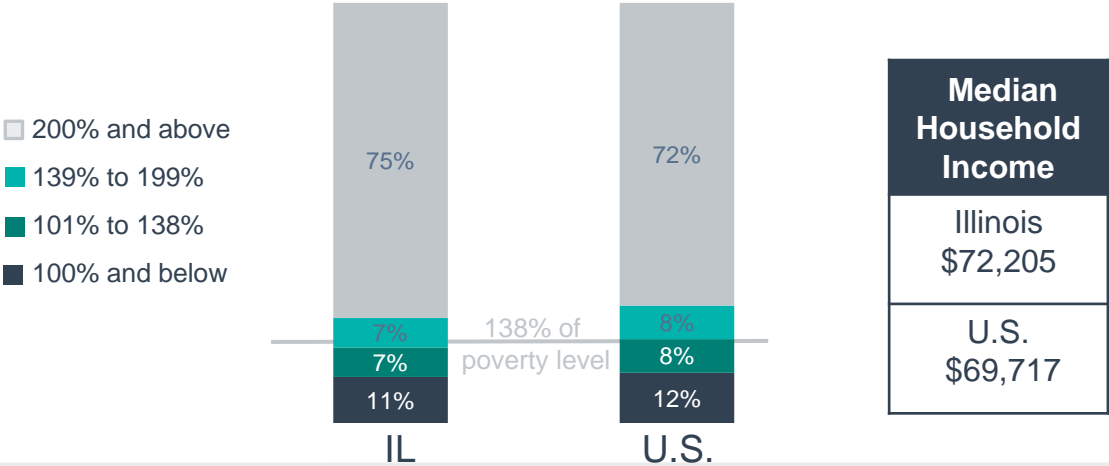
# B. Illinois Health Financing System Overview

# B.1. Population Demographics

Total Illinois Population- 12,671,469  
 Estimated SMI Population- 922,350



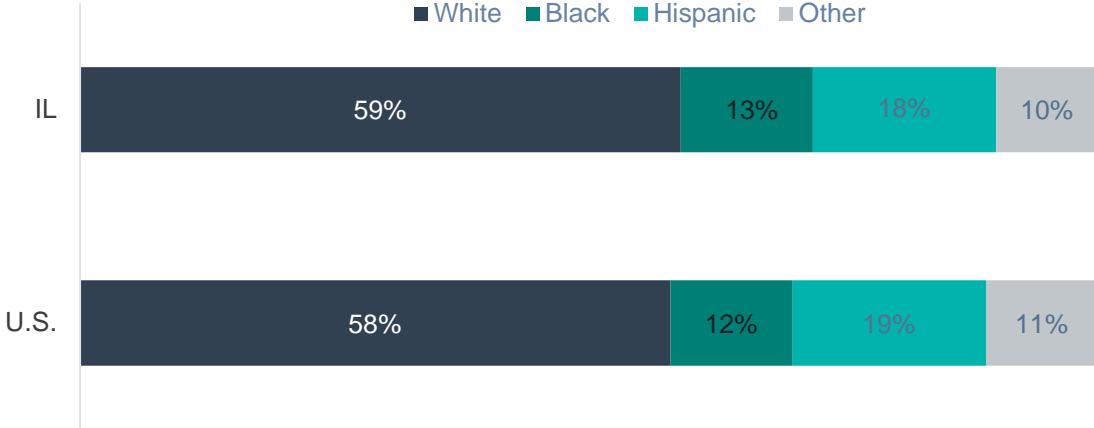
Population Distribution By Income To Poverty Threshold Ratio



Population Distribution By Age



Illinois & U.S. Racial Composition

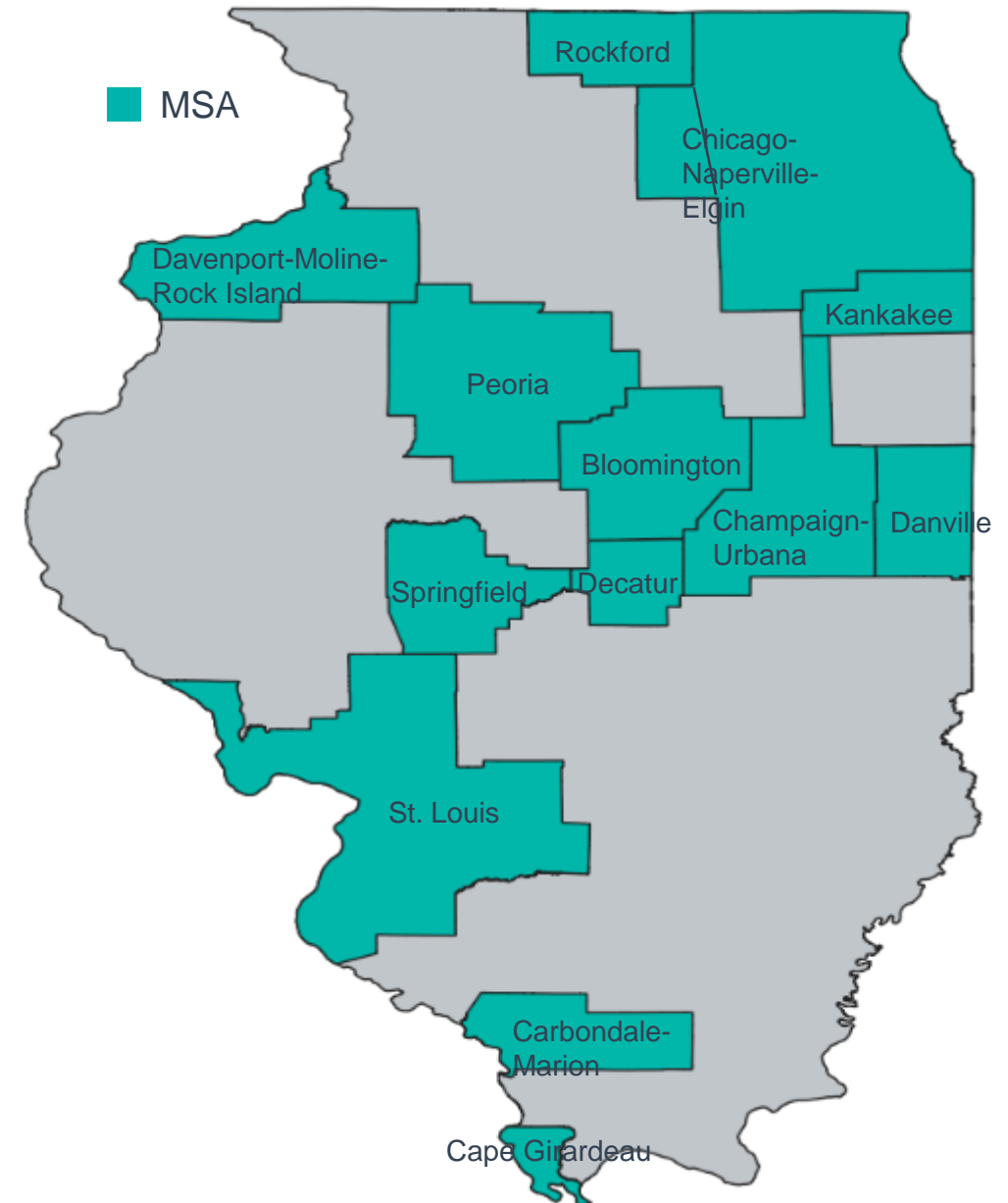


\*Totals may not equal 100% due to rounding

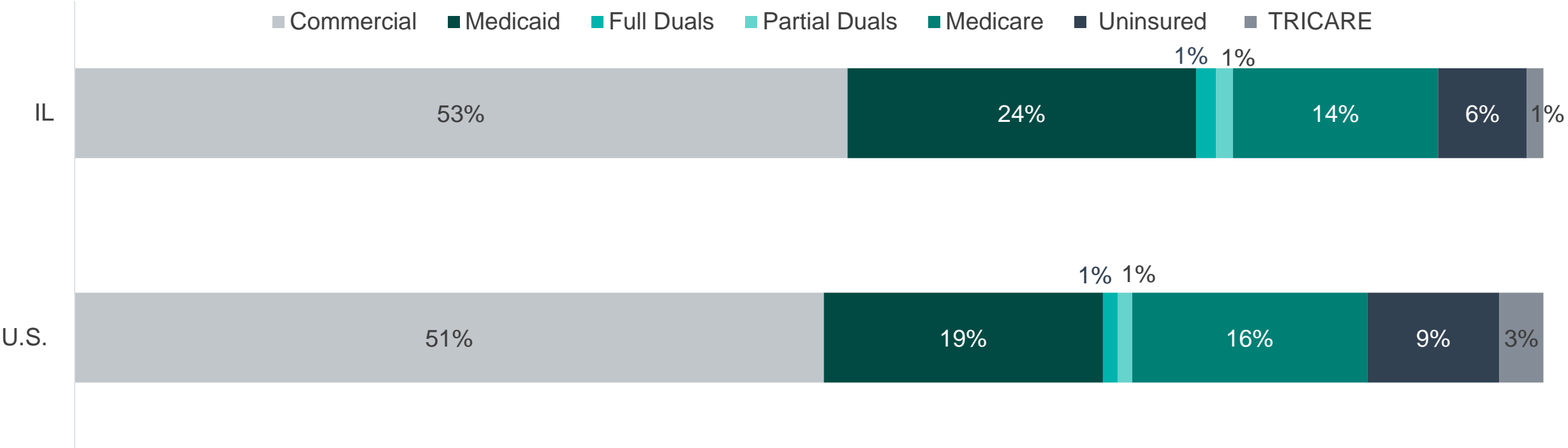
## B.2. Population Centers

Metropolitan Statistical Areas (MSAs)*		
MSA	IL MSA Residents	Percent Of Population
Total MSAs	14,545,350	N/A
Chicago-Naperville-Elgin, IL-IN-WI	9,509,934	75%
St Louis, MO-IL	2,809,299	22%
Peoria, IL	398,224	3%
Davenport-Moline-Rock Island, IA-IL	381,568	3%
Rockford, IL	336,278	3%
Champaign-Urbana, IL	222,696	2%
Springfield, IL	206,898	2%
Bloomington, IL	167,699	1%
Carbondale-Marion, IL	132,907	1%
Kankakee, IL	106,601	1%
Decatur, IL	102,432	1%
Other MSAs	170,794	1%

\*Totals may be over 100% due to some MSA areas crossing state lines.



# B.3. Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding

# B.3. SMI Population Distribution By Payer: National vs. State

Commercial   Medicaid   Full Duals   Partial Duals   Medicare   Uninsured   TRICARE



Totals may not equal 100% due to rounding

## B.4. Largest Illinois Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
Blue Cross Blue Shield of Illinois	Commercial	7,784,590
Medicare fee-for-service (FFS)	Medicare FFS	1,426,882
MeridianHealth	Medicaid managed care	898,666
Blue Cross Community Health Plans	Medicaid managed care	752,655
Medicaid FFS	Medicaid	742,787
UnitedHealthcare ASO	Commercial administrative services only(ASO)	650,823
Coventry ASO	Commercial ASO	594,286
Cigna ASO	Commercial ASO	567,500
CountyCare	Medicaid managed care	449,019
Aetna Better Health	Medicaid managed care	431,680

\* Medicaid enrollment as of January 2023; TRICARE enrollment as of January 2023; Commercial as of January 2023; Medicare enrollment as of January 2023

## B.4. Largest Illinois Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Blue Cross Blue Shield of Illinois	Commercial	7,784,590	319,168
Medicare FFS	Medicare	1,426,882	228,301
MeridianHealth	Medicaid managed care	898,666	77,285
Blue Cross Community Health Plan	Medicaid managed care	752,655	64,728
Medicaid FFS	Medicaid	742,787	63,880
CountyCare	Medicaid managed care	449,019	38,616
Aetna Better Health	Medicaid managed care	431,680	37,124
Cigna	Commercial ASO	594,937	83,291
Aetna Better Health	Medicaid managed care	424,914	59,488
Meridian Health Plan Family Health	Medicaid managed care	363,116	31,228

\* Medicaid enrollment as of January 2023; TRICARE enrollment as of January 2022; Commercial as of January 2023; Medicare enrollment as of January 2023

## B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Insurance Marketplace Percent	3%
Type of Marketplace	Federal-State Partnership
Individual Enrollment Contact	<a href="https://www.healthcare.gov/">https://www.healthcare.gov/</a>
	1-800-318-2596
Small Business Enrollment Contact	<a href="https://www.healthcare.gov/small-businesses/">https://www.healthcare.gov/small-businesses/</a>
	1-800-706-7893

2023 Individual Market Health Plans
1. Aetna
2. Celtic Insurance Co
3. Health Alliance Medical Plans, Inc
4. Health Care Service Corp
5. Cigna
6. Quartz
7. MerCare HMO
8. SSM Health
9. Oscar
10. Molina
11. UnitedHealthcare

2023 Small Group Market Plans
1. Health Alliance Medical Plans

## B.6. Accountable Care Organizations

### Medicare Shared Savings ACOs

- |  |  |
|--|--|
| 1. Advocate Physician Partners Accountable Care              | 21. Ingalls Care Network   |
| 2. Aledade Accountable Care 13, LLC                          | 22. Keep Well ACO, LLC   |
| 3. America's ACO, LLC  | 23. Mercy Health Corporation   |
| 4. AMITA Health Accountable Care Organization                | 24. Mercy Health Network ACO, LLC                                    |
| 5. AmpliPHY of Kentucky ACO, LLC                             | 25. MHN ACO, LLC   |
| 6. Ascension Care Management Health Partners Evansville, LLC | 26. NorthShore Physician Based Care                                  |
| 7. Baptist Health Care Partners, LLC                         | 27. Northwest Community HealthCare                                   |
| 8. BJC HealthCare ACO, LLC                                   | 28. Northwestern Medicine ACO  |
| 9. Caravan Health ACO 20, LLC                                | 29. OSF Healthcare System  |
| 10. Caravan Health ACO 22, LLC                               | 30. Primary Comprehensive Care ACO                                   |
| 11. Centegra Health & Wellness Network                       | 31. Prime Accountable Care   |
| 12. Community Healthcare Partners ACO, Inc                   | 32. Rush Health ACO, Inc.  |
| 13. DMH Health Network                                       | 33. Springfield Clinic ACO   |
| 14. DuPage Medical Group ACO                                 | 34. SSM ACO, LLC   |
| 15. Edward-Elmhurst Accountable Care                         | 35. SSM IL ACO, LLC  |
| 16. Essential Health Partners ACO                            | 36. St Luke's ACO, LLC   |
| 17. Franciscan ACO, Inc                                      | 37. UnityPoint Accountable Care, LLC                                 |
| 18. Genesis Accountable Care Organization, LLC               | 38. University of Chicago Care Network Accountable Care Organization |
| 19. HSHS ACO   | 39. USMM Accountable Care Partners                                   |
| 20. Illinois Rural Community Care Organization (IL-RCCO)     | 40. VillageMD Chicago ACO  |

## B.6. Accountable Care Organizations

### Next Generation ACOs

1. Deaconess Care Integration, LLC
2. UnityPoint Accountable Care, LLC

### End-Stage Renal Disease Model ACOs

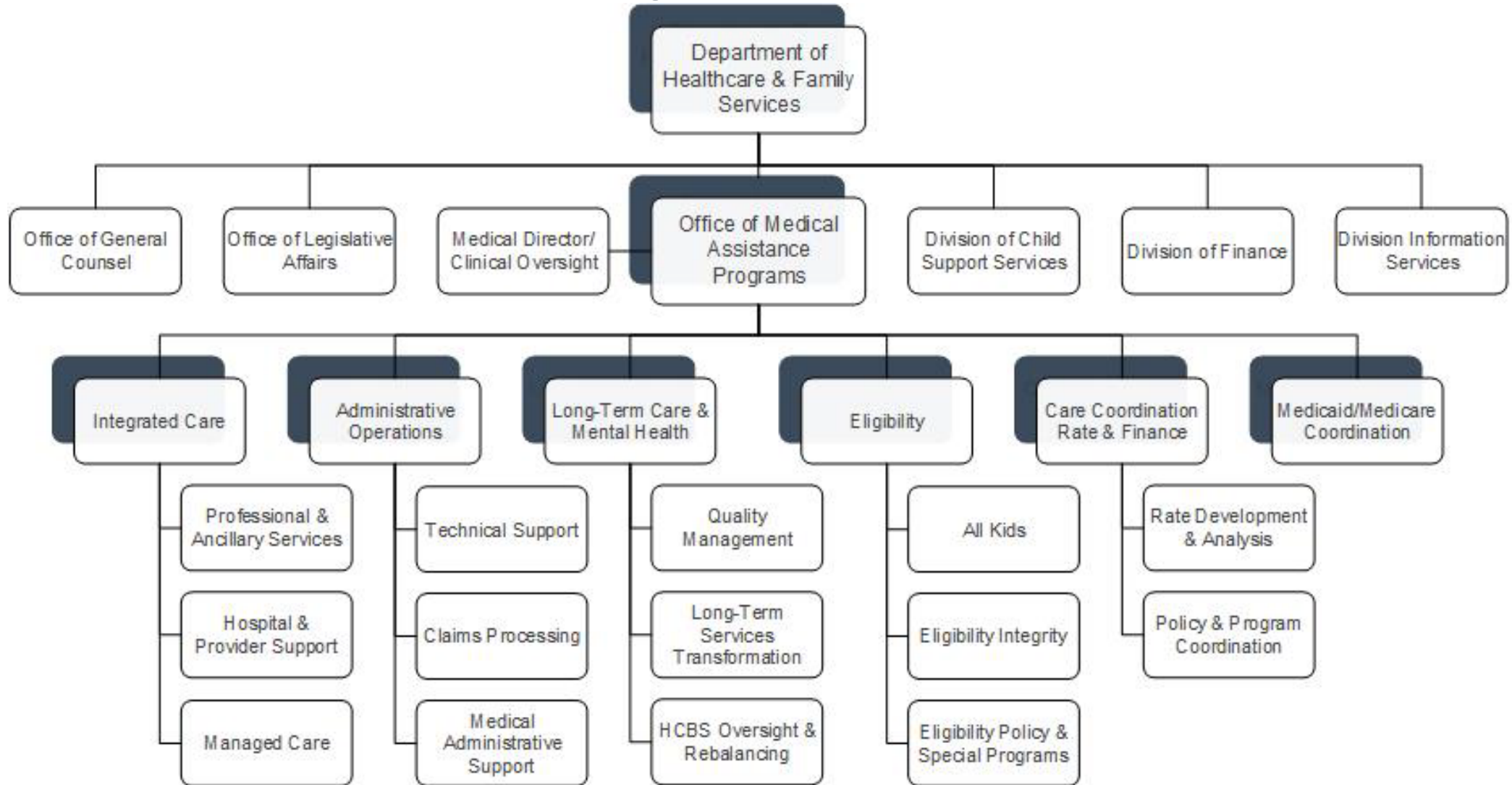
1. Fresenius Seamless Care of Central Illinois
2. Fresenius Seamless Care of Chicago

### Commercial ACOs

ACO	Commercial Insurer
Adventist Health-Illinois	Cigna
Advocate Physician Partners Accountable Care	UnitedHealthcare, Blue Cross Blue Shield Illinois
Aetna Whole Health Chicago	Aetna
AMITA Health Accountable Care Organization	Blue Cross Blue Shield Illinois
Blue Cross and Blue Shield of Illinois / NorthShore University Health System	Blue Cross Blue Shield Illinois
Northwestern Medicine Physician Partners ACO	Cigna
Centegra Health & Wellness Network	Blue Cross Blue Shield Illinois
Kane County IPA	Blue Cross Blue Shield Illinois
NexusACO	UnitedHealthcare
OSF Healthcare System	Blue Cross Blue Shield Illinois

## C. Medicaid Administration, Governance & Operations

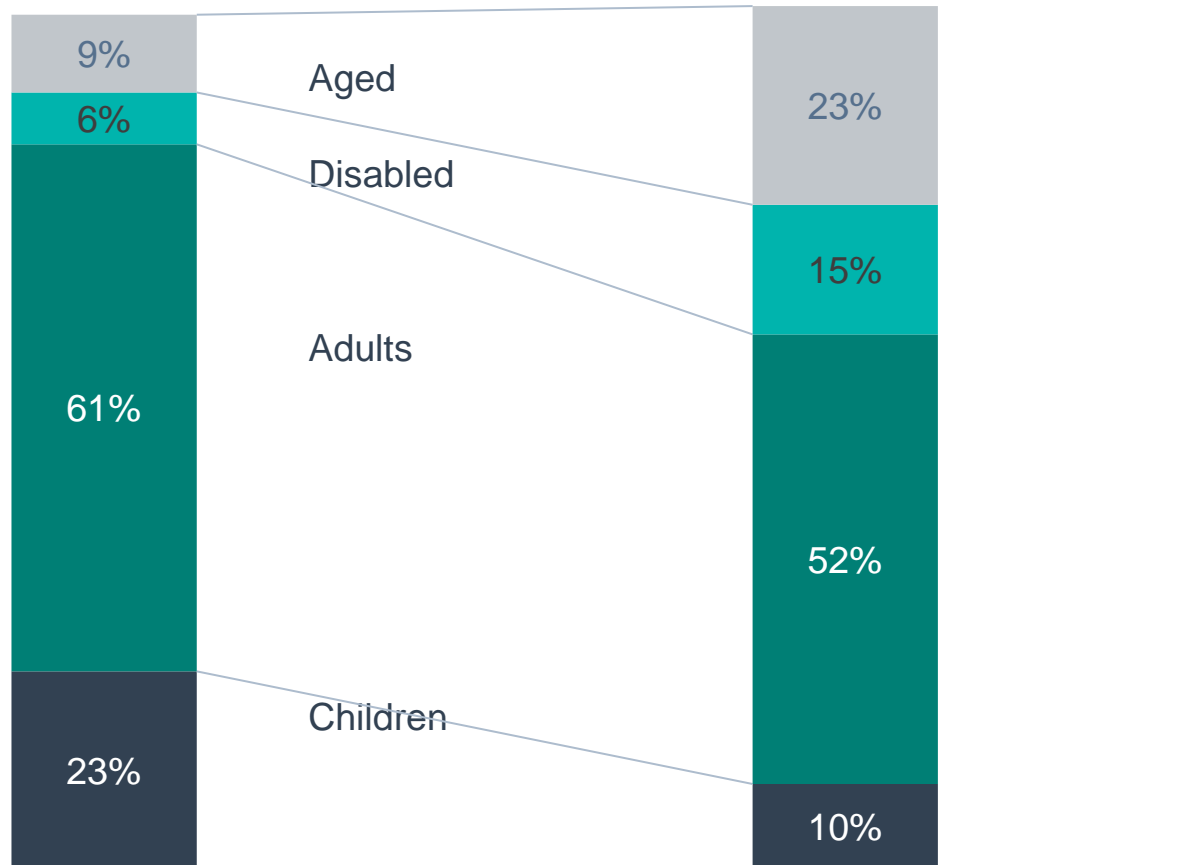
# C.1. Medicaid Governance: Organization Chart



## C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Theresa Eagleson	Director	Department of Healthcare and Family Services	theresa.eagleson@illinois.gov
Jane Longo	Deputy Director of New Initiatives	Department of Healthcare and Family Services	jane.longo@illinois.gov
Arvind K. Goyal	Medical Director, Medicaid Director	Division of Medical Programs	arvind.goyal@illinois.gov
Kelly Cunningham	Deputy Administrator for Long Term Care	Division of Medical Programs	kelly.cunningham@illinois.gov
Vacant	Deputy Administrator for Eligibility Policy	Division of Medical Programs	N/A
Robert Mendonsa	Deputy Administrator of Care Coordination	Division of Medical Programs	robert.mendonsa@illinois.gov

## C.2. Medicaid Program Spending By Eligibility Group



\*Percent of Total Medicaid Population

Percent of Total Medicaid Spending

\*Based on FY 2020 data

Totals may not equal 100% due to rounding

Medicaid Spending Per Enrollee, FY 2020		
	U.S.	IL
All populations	\$8,718	\$7,993
Children	\$3,495	\$3,432
Adults	\$5,461	\$6,075
Expansion adults	\$7,227	\$7,053
Blind and disabled	\$23,123	\$16,752
Aged	\$18,552	\$19,008

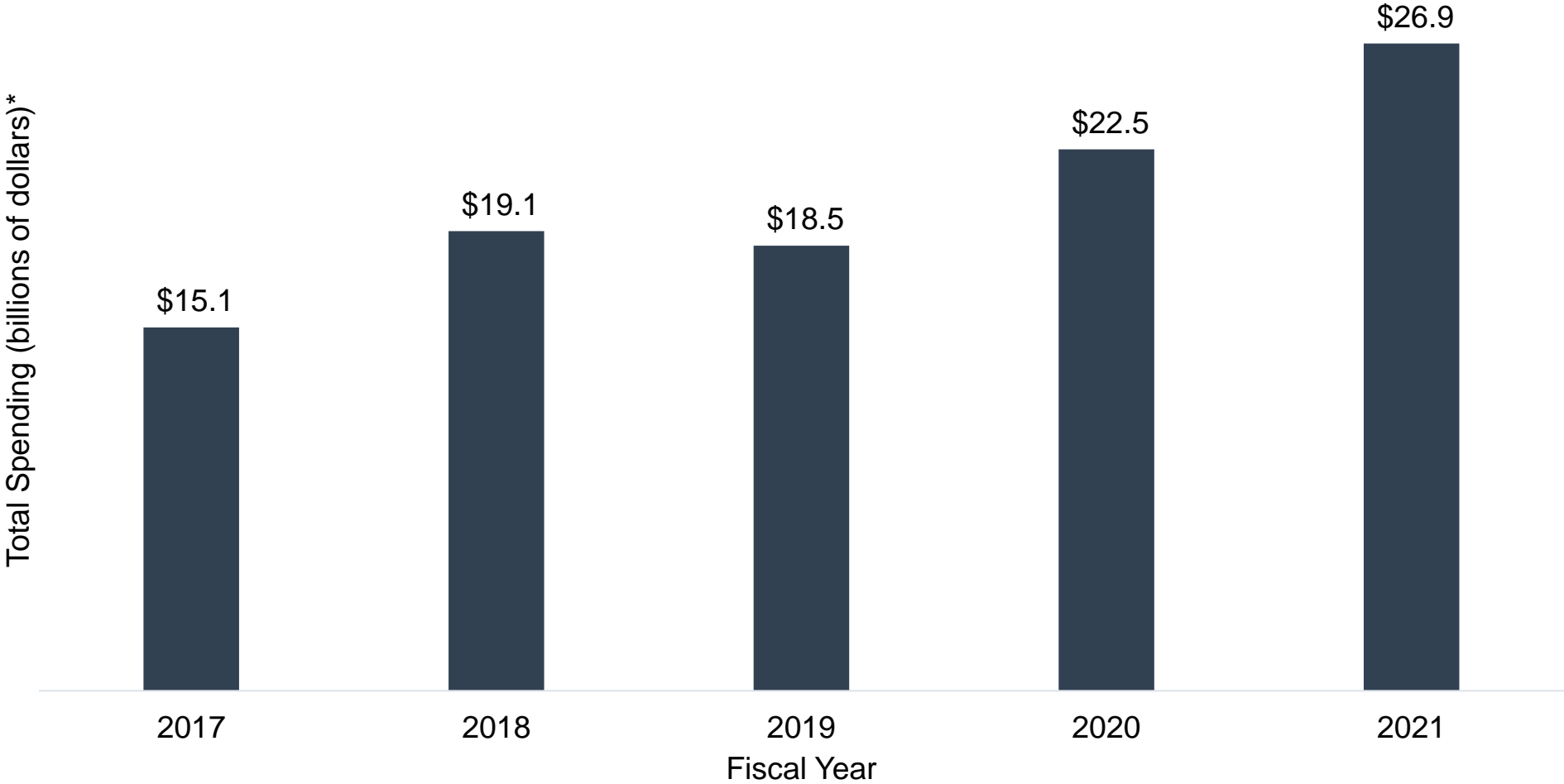
## C.2. Medicaid Program Spending: Budget

Budget Item	SFY 21 Spending	Percent Of Budget
Managed care and premium assistance	\$19,967,000,000	74%
Hospital	\$2,918,000,000	11%
Institutional LTSS	\$1,319,000,000	5%
Other acute	\$1,059,000,000	4%
Home- and community-based LTSS	\$790,000,000	3%
Medicare premiums and coinsurance	\$629,000,000	2%
Physician	\$126,000,000	<1%
Clinic and health center	\$77,000,000	<1%
Dental	\$15,000,000	<1%
Other practitioner	\$14,000,000	<1%
Drugs	\$5,000,000	<1%
<b>Budget Total: \$26,919,000,000</b>		

Federal & County Financial Participation	
FY 2023 Federal Medical Assistance Percentage (FMAP)	56.2%
CY 2023 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	No

\*Totals may not equal 100% due to rounding

# C.2. Medicaid Program Spending: Change Over Time



## C.3. Medicaid Expansion Status

Illinois Medicaid Expansion Characteristics	
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	<ul style="list-style-type: none"> <li>• 133% of the Federal Poverty Level (FPL)</li> <li>• Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded when determining eligibility</li> </ul>
Legislation Used To Expand Medicaid	Senate Bill 26, 98th General Assembly
Number Of Individuals Enrolled In The Expansion Group (March 2023)	942,399
Number Of Enrollees Newly Eligible Due To Expansion	842,685
Benefits Plan For Expansion Population	The alternative benefit plan benefits are identical to state plan benefits.

## C.4. Medicaid Program Benefits

### Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

### Illinois's Optional Services

1. Case management services
2. Nurse anesthetist and clinical nurse specialist services
3. Chiropractic services
4. Clinical services
5. Dental services, including dentures
6. Diagnostic, screening, and preventive services
7. Rehabilitative services
8. Durable medical equipment and supplies
9. Optometry and eyeglasses
10. Hospice services
11. Inpatient psychiatric services for individuals 21 and under
12. Intermediate care facility services for individuals with intellectual disabilities
13. Nursing facility services for individuals under 21 years old
14. Occupational and physical therapy
15. Podiatric services
16. Prescribed drugs
17. Prosthetic devices
18. Tuberculosis-related services
19. Speech, hearing, and language disorder services

# D. Medicaid Financing & Service Delivery System

# D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	Medicaid Fee-For-Service (FFS)	Medicaid Managed Care
Enrollment (January 2023)	742,787	3,006,832
SMI Enrollment	<ul style="list-style-type: none"> <li>Illinois does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI; however, individuals with SMI may be enrolled in FFS based on other criteria.</li> <li>Estimated 20% of the SMI population in FFS, 80% in managed care</li> </ul>	
Management	Department of Healthcare and Family Services	Six health plans
Payment Model	FFS	Capitated rate
Geographic Service Area	Statewide	Statewide

**Total Medicaid: 3,749,619 | Total Medicaid With SMI: 599,939**

# D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment		
Total Medicaid population distribution	<ul style="list-style-type: none"> <li>As of January 2023: 20% in fee-for-service (FFS), 80% in managed care</li> </ul>	
SMI population inclusion in managed care	<ul style="list-style-type: none"> <li>Illinois does not specifically preclude individuals with SMI from enrolling in managed care.</li> <li>Estimated 20% of the SMI population in FFS, 80% in managed care</li> </ul>	
Dual eligible population inclusion in managed care	<ul style="list-style-type: none"> <li>Managed care is mandatory for dual eligibles receiving long-term services and supports (LTSS).</li> <li>Estimated 64% of the Dual Eligible population in FFS, 36% in managed care.</li> </ul>	
Long-term services and supports population inclusion in managed care	<ul style="list-style-type: none"> <li>A majority of beneficiaries, except individuals with I/DD, receive LTSS services through the health plan's capitation rate.</li> </ul>	
Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	FFS Population	Managed Care Population
Traditional Behavioral Health	Covered FFS by the state	Included in the health plan's capitation rate
Specialty Behavioral Health	Covered FFS by the state	Included in the health plan's capitation rate
Pharmaceuticals	Covered FFS by the state	Included in the health plan's capitation rate
Long-Term Services and Supports (LTSS)	Covered FFS by the state	<ul style="list-style-type: none"> <li>LTSS for most populations are included in the health plan's capitation.</li> <li>LTSS for the I/DD population are not included but may be added to the health plan contract with 180 days notice.</li> </ul>

## D.1. Medicaid Care Coordination Initiatives

Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	Active Program	Description
Managed Care Health Plan	✓	Medicaid health plans are responsible for care coordination.
Primary Care Case Management (PCCM)		Illinois discontinued its PCCM program in December 2017.
Accountable Care Organization (ACO) Program		Illinois transitioned its Medicaid ACO enrollees to full-risk managed care in 2016.
Affordable Care Act Model Health Home	✓	The state had delayed implementation of the health home program as it reviews the model, the state is currently withdrawing SPA's that had been previously approved.
Patient-Centered Medical Home (PCMH)		None.
Dual Eligible Demonstration	✓	The state has a dual demonstration which extends until December 2023.
Managed Long-Term Services and Supports (MLTSS)	✓	Health plans are responsible for providing LTSS to the managed care population and dual eligibles requiring LTSS.
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	Illinois operates nine CCBHCs under federal funding.

## D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles		Individuals not requiring LTSS services and also reside in a dual eligible demonstration regions.	Individuals requiring LTSS services are required to enroll in managed care.
Medicaid expansion			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Individuals in foster care			X*
Other populations	<ul style="list-style-type: none"> <li>Limited benefits enrollees</li> <li>Individuals with third-party coverage</li> <li>Individuals eligible through spend-down</li> <li>Incarcerated or forensically institutionalized individuals</li> </ul>	<ul style="list-style-type: none"> <li>Alaskan natives</li> <li>American indigenous peoples</li> </ul>	

\*On September 1, 2020, the Illinois Department of Healthcare and Family Services transitioned foster care youth to YouthCare, a Medicaid managed care program operated by Meridian Health, a Centene subsidiary.

## D.2. Medicaid FFS Program: Overview

- FFS enrollment as of January 2023 was 742,787.

## D.2. Medicaid FFS Program: Behavioral Health Benefits

- All behavioral health services are financed FFS by the state.
- Supported employment, crisis intervention, respite services, intensive in-home services, peer recovery support, evidence-based home visiting, and addiction case management are available through pilot programs in select areas of the state. See [section D.6.](#) for more information.

FFS Mental Health Benefits	
1.	Inpatient treatment
2.	Assessment and evaluation
3.	Crisis services
4.	Medication administration, management, monitoring, and training
5.	Individual, family, and group psychotherapy
6.	Community support services and team
7.	Assertive community treatment (ACT)
8.	Psychosocial rehabilitation services
9.	Intensive outpatient
10.	Case management
11.	Transition linkage and aftercare
12.	Applied Behavioral Analysis

FFS Addiction Treatment Benefits	
1.	Inpatient treatment
2.	Outpatient treatment
3.	Intensive outpatient treatment
4.	Residential treatment including in IMDs
5.	Medication assisted treatment
6.	Medically supervised withdrawal management

## D.2. Medicaid FFS Program: SMI Population

- Illinois does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI; however, individuals with SMI may be enrolled in FFS based on other criteria.
- As of January 2023, *OPEN MINDS* estimates that 20% of the SMI population was enrolled in FFS.

## D.2. Medicaid FFS Program: Pharmacy Benefit

Illinois FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	No
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes
State Uses A PDL For Mental Health Drugs	Yes, antidepressants and antipsychotics are included on the PDL.
State Uses A PDL For Addiction Treatment Drugs	All drugs for the treatment of addiction are preferred.
Coverage Of Antipsychotic Injectable Medications	Yes, antipsychotic injectable medications are included on the PDL and require prior authorization even if preferred.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	<ul style="list-style-type: none"> <li>• Prior authorization is required for all antipsychotics prescribed to children under eight and long-term care residents.</li> <li>• Non-preferred drugs require prior approval.</li> </ul>
State Has A Pharmacy Lock-In Program Or Other Restriction Program	In the Recipient Restriction Program, the state uses statistical norms to identify individuals receiving medical services, including pharmacy, in excess of need. For these individuals, a primary provider is identified to authorize the Medicaid services for which the participant has been restricted.

## D.3. Medicaid Managed Care Program: Overview

- Managed care enrollment as of January 2023 was 3,006,832.
- Illinois expanded its redesigned managed care program statewide, HealthChoice Illinois, in April 2018.
- Under the new program, there are four statewide commercial health plans with two additional health plans available only in Cook County. Additionally, there are two plans that are just for dual eligibles.
  - The health plans serve most populations and are at-risk for physical health, behavioral health, and long-term services and supports.
- As of July 1, 2019, Illinois fully integrated home- and community-based services (HCBS) in managed care for individuals enrolled in the Elderly, Supportive Living, and Division of Rehabilitation home- and community-based services (HCBS) waivers.
- As of July 1, 2019, the state added a benefit package of managed long-term services and supports for dual eligibles that was made available statewide through the health plans. For more information, see [section E.3.](#)
- The HealthChoice Illinois contract includes a requirement for the health plans to report on their progress towards enrolling provider organizations in arrangements that incentivize value-based care.

## D.3. Medicaid Managed Care Program: Health Plan Characteristics

Aetna Better Health	Blue Cross Blue Shield Of Illinois
<ol style="list-style-type: none"> <li>1. Profit status: For-profit</li> <li>2. Parent company: Aetna/ CVS</li> <li>3. Behavioral health subcontractor: None</li> <li>4. Pharmacy benefits manager: CVS Caremark</li> <li>5. Managed care programs: HealthChoice Illinois, Medicare-Medicaid Alignment Initiative (MMAI)</li> <li>6. Cook County only: No</li> <li>7. Enrollment share: 15%</li> </ol>	<ol style="list-style-type: none"> <li>1. Profit status: Non-profit</li> <li>2. Parent company: Health Care Service Corporation</li> <li>3. Behavioral health subcontractor: None</li> <li>4. Pharmacy benefits manager: Prime Therapeutics</li> <li>5. Managed care programs: HealthChoice Illinois, MMAI</li> <li>6. Cook County only: No</li> <li>7. Enrollment share: 26%</li> </ol>
CountyCare Health Plan	Humana Health Plan
<ol style="list-style-type: none"> <li>1. Profit status: Non-profit</li> <li>2. Parent company: Cook County Health and Hospitals System</li> <li>3. Behavioral health subcontractor: None</li> <li>4. Pharmacy benefits manager:</li> <li>5. Managed care programs: HealthChoice Illinois</li> <li>6. Cook County only: Yes</li> <li>7. Enrollment share: 15%</li> </ol>	<ol style="list-style-type: none"> <li>1. Profit status: For-profit</li> <li>2. Parent company: Humana, Inc.</li> <li>3. Behavioral health subcontractor: Beacon Health Options</li> <li>4. Pharmacy benefits manager: None</li> <li>5. Managed care programs: MMAI</li> <li>6. Cook County only: No</li> <li>7. Enrollment share: &lt;1%</li> </ol>

# D.3. Medicaid Managed Care Program: Health Plan Characteristics

Meridian Health Plan Of Illinois	
1.	Profit status: For-profit
2.	Parent company: Centene-WellCare
3.	Behavioral health subcontractor: Cenpatico
4.	Pharmacy benefits manager: MeridianRx
5.	Managed care programs: HealthChoice Illinois, MMAI
6.	Cook County only: No
7.	Enrollment share: 31%

Molina Healthcare of Illinois	
1.	Profit status: For-profit
2.	Parent company: Molina
3.	Behavioral health subcontractor: None
4.	Pharmacy benefits manager: None
5.	Managed care programs: HealthChoice Illinois, MMAI
6.	Cook County only: No
7.	Enrollment share: 12%

## D.3. Medicaid Managed Care Program: Behavioral Health Benefits

- Behavioral health and pharmacy benefits are included in the health plan’s capitation rate.
- In lieu of state plan services, health plans may provide up to 15 days per month of cost-effective behavioral health inpatient services in an institution for mental diseases (IMD) to individuals ages 21 to 64. Enrollees are not required to accept this substitution.
- Supported employment, crisis intervention, respite services, intensive in-home services, peer recovery support, evidence-based home visiting, and addiction case management are available through pilot programs in select areas of the state. See [section D.6.](#) for more information.

### Managed Care Mental Health Benefits

1. Inpatient treatment
2. Assessment and evaluation
3. Crisis services
4. Medication administration, management, monitoring, and training
5. Individual, family, and group psychotherapy
6. Community support services and team
7. Assertive community treatment (ACT)
8. Psychosocial rehabilitation services
9. Intensive outpatient
10. Case management
11. Transition linkage and aftercare
12. Applied Behavioral Analysis

### Managed Care Addiction Treatment Benefits

1. Inpatient treatment
2. Outpatient treatment
3. Intensive outpatient treatment
4. Residential treatment including in IMDs
5. Medication assisted treatment
6. Medically supervised withdrawal management

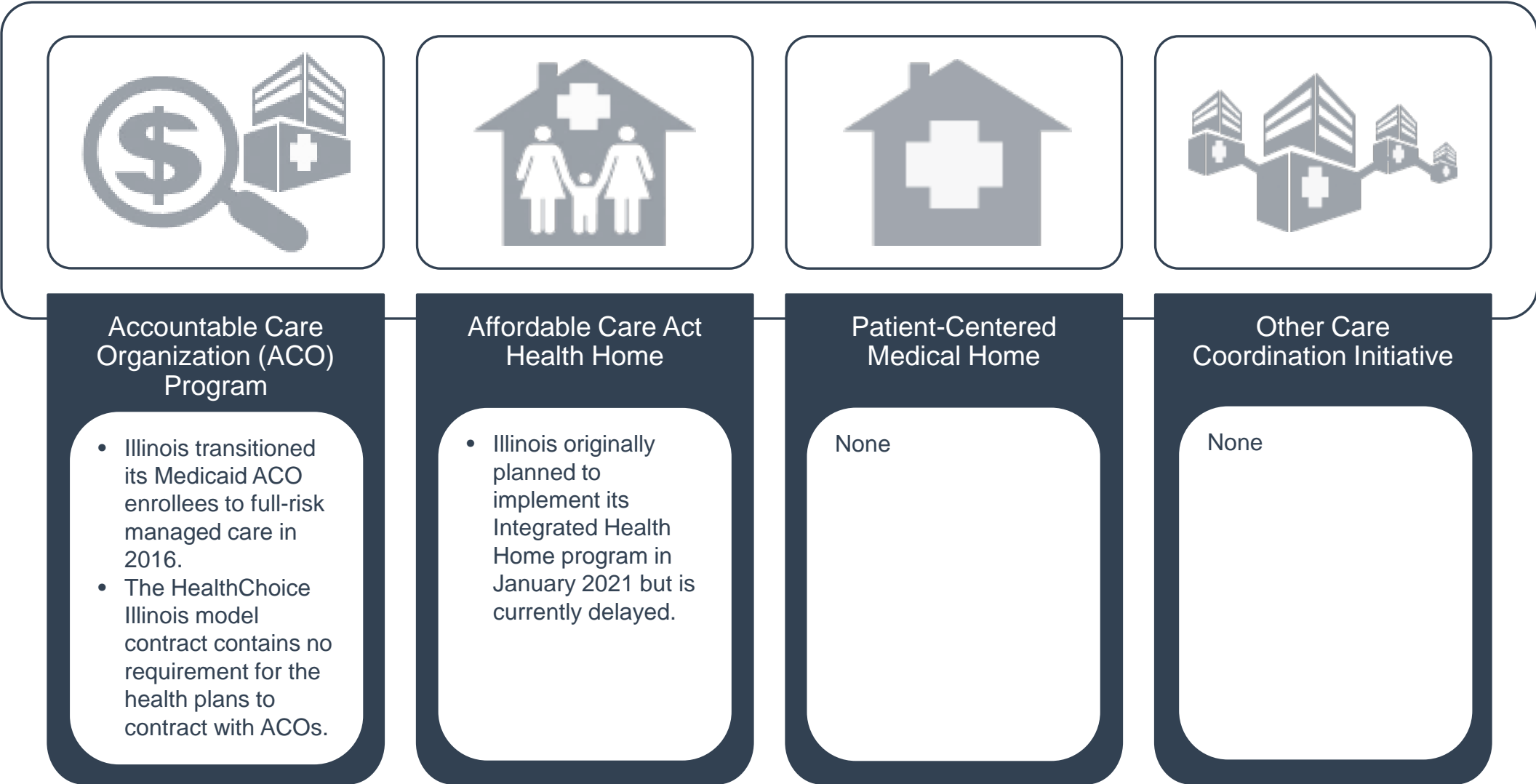
## D.3. Medicaid Managed Care Program: SMI Population

- Illinois does not specifically preclude individuals with SMI from enrolling in managed care based on a diagnosis of SMI; however, individuals with SMI may be enrolled in FFS based on other criteria.
- As of January 2023, *OPEN MINDS* estimates that 80% of the SMI population was enrolled in managed care.

# D.3. Medicaid Managed Care Program: Pharmacy Benefit

Illinois Managed Care Program Pharmacy Benefit	
Responsible For Financing General Pharmacy Benefit	Health plan
Responsible For Financing Mental Health Pharmacy Benefit	Health plan
Health Plan Uses A Preferred Drug List (PDL) For General Pharmacy	The state has implemented a single, uniform PDL.
Health Plan Uses A PDL For Mental Health Drugs	
Health Plan Uses A PDL For Addiction Treatment Drugs	
Health Plan Use Of Utilization Restrictions For Mental Health & Addiction Treatment Drugs	Health plans are responsible for setting utilization restriction including step therapy and prior authorizations.
Health Plan Allowed To Implement Pharmacy Lock-In Program	Yes, health plans must have a recipient restriction program that limits individuals to one primary care provider or pharmacy for a reasonable period of time.

# D.4. Medicaid Program: Care Coordination Initiatives



## D.4. State Medicaid Health Home Characteristics

Illinois has delayed the implementation of its Integrated Health Home program. In its reasoning to CMS, Illinois stated it needed to explore separate health home models for children and adults. The below chart describes the health home program as it stood before the delay. In December 2020, Illinois began the process of rolling this program out again. Currently, the state is working on withdrawing approved SPA's.

<b>Integrated Health Homes Concept- Adult</b>	
<b>Target Population</b>	<p>The state plans to include all full benefit Medicaid enrollees in its health home program. Members will be stratified by need. Members with the lowest level of need will be incorporated into the program at a later date via a separate application. Currently there are 3 tiers that vary by severity of care.</p> <p>Tier A: Individuals with high physical and high behavioral health needs            Tier B: Individuals with low physical and high behavioral health needs            Tier C: Individuals with high physical and low behavioral health needs</p>
<b>Enrollment Model</b>	<ul style="list-style-type: none"> <li>• Health plans will assign each member a tier based on level of need.</li> <li>• The assigned tier and predetermined attribution logic will be used to assign an individual to a health home provider organization.</li> <li>• Individuals may opt out of the program or choose a different health home.</li> </ul>
<b>Geographic Service Area</b>	Statewide
<b>Care Delivery Model</b>	<ul style="list-style-type: none"> <li>• The program goal is integration of physical health, behavioral health, and social care services.</li> <li>• Health homes, which can be any type of organization, would be responsible for core health home services.</li> <li>• Health homes will have to utilize interdisciplinary care teams.</li> </ul>
<b>Payment Model</b>	<ul style="list-style-type: none"> <li>• Per member per month payment based on tier ranging from \$159 to \$197</li> <li>• The health plans will be responsible for paying for health home services for managed care members using the state set rates</li> <li>• Payment based on health home performance on quality and efficiency measures for health homes with more than 500 enrollees</li> </ul>
<b>Practice Performance &amp; Improvement</b>	<ul style="list-style-type: none"> <li>• Reporting on CMS health home measures</li> <li>• Reporting on additional measures such as antidepressant medication management, breast cancer screening, and behavioral health related emergency department visits per 1,000</li> </ul>

## D.4. State Medicaid Health Home Characteristics

Integrated Health Homes Concept- Child	
<b>Target Population</b>	<p>The state plans to include all full benefit Medicaid enrollees in its health home program. Members will be stratified by need. Members with the lowest level of need will be incorporated into the program at a later date via a separate application. Currently there are 5 tiers that vary by severity of care.</p> <p>Tier A1: Individuals with low physical and high behavioral health needs            Tier A2: Individuals with high physical and high behavioral health needs            Tier B1: Individuals with low physical and moderate behavioral health needs            Tier B2: Individuals with high physical and moderate behavioral health needs            Tier C: Individuals with high physical and low behavioral health needs</p>
<b>Enrollment Model</b>	<ul style="list-style-type: none"> <li>• Health plans will assign each member a tier based on level of need.</li> <li>• The assigned tier and predetermined attribution logic will be used to assign an individual to a health home provider organization.</li> <li>• Individuals may opt out of the program or choose a different health home.</li> </ul>
<b>Geographic Service Area</b>	Statewide
<b>Care Delivery Model</b>	<ul style="list-style-type: none"> <li>• The program goal is integration of physical health, behavioral health, and social care services.</li> <li>• Health homes, which can be any type of organization, would be responsible for core health home services.</li> <li>• Health homes will have to utilize interdisciplinary care teams.</li> </ul>
<b>Payment Model</b>	<ul style="list-style-type: none"> <li>• Per member per month payment based on tier ranging from \$162 to \$976</li> <li>• The health plans will be responsible for paying for health home services for managed care members using the state set rates</li> <li>• Payment based on health home performance on quality and efficiency measures for health homes with more than 500 enrollees</li> </ul>
<b>Practice Performance &amp; Improvement</b>	<ul style="list-style-type: none"> <li>• Reporting on CMS health home measures</li> <li>• Reporting on additional measures such as school attendance, justice system involvement, child welfare system involvement, IM-CANS Improvement, and housing stability.</li> </ul>

## D.5. Medicaid Program: Demonstration Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Caps	Effective Date	Expiration Date
Illinois Continuity of Care & Administrative Simplification	Seeks to address coverage for pregnant women 60 days postpartum, address the churning between FFS and Managed Care due to late paperwork, and implementing hospital presumptive eligibility.	1115	N/A	01/19/2021	12/31/2025
Illinois' Behavioral Health Transformation	Tests a combination of initiatives to integrate physical and behavioral health services. See <a href="#">section D.6.</a>	1115	Enrollment caps vary by pilot	07/01/18	06/20/2023
IL MLTSS Waiver (IL-01)	Implements a managed long-term services and support program in the state.	1915(b)	N/A	01/01/2020	12/31/2024

## D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2023 Enrollment Cap	Operating Unit	Concurrent Management Authority?
IL HCBS Waiver for Persons Who are Elderly (0143.R06.00)	Individuals aged 65 and above and individuals aged 60 to 64 with physical disabilities	141,209	Department of Aging	Yes; 1915 (b) waiver and SPA
IL Persons with Disabilities (0142.R06.00)	Physically disabled individuals ages 0 to 59	32,401	Division of Rehabilitation Services	Yes; 1915 (b) waiver and SPA
IL Adults w/DD Waiver (0350.R03.00)	Individuals aged 18 and above with autism, developmental disabilities, or intellectual disabilities	25,087	Division of Developmental Disabilities	None
IL Supportive Living Program (0326.R03.00)	Individuals aged 65 and above and individuals ages 22 to 64 with physical disabilities	15,246	Division of Medical Programs	Yes; 1915 (b) waiver and SPA
IL HCBS Waiver for Persons w/HIV or AIDS (0202.R05.00)	Individuals of all ages with HIV or AIDS	1,672	Division of Rehabilitation Services	Yes; 1915 (b) waiver and SPA

## D.5. Medicaid Program: Section 1915 (c) HCBS Waivers (Cont'd)

Waiver Title	Target Population	2023 Enrollment Cap	Operating Unit	Service Management Authority?
IL Medically Fragile, Technology Dependent Waiver (0278.R04.00)	Individuals under age 21 who are medically fragile or technology dependent	1,696	University of Illinois at Chicago, Division of Specialized Care for Children	None
IL Support Waiver for Children and Young Adults with Developmental Disabilities (0464.R02.00)	Individuals ages 3 to 21 with autism, developmental disabilities, or intellectual disabilities	1,440	Division of Developmental Disabilities (DDD)	None
IL Residential Waiver for Children and Young Adults with DD (0473.R03.00)	Eligible children and young adults with developmental disabilities from age three through age twenty-one who meet functional and financial eligibility.	295	IDHS, DDD	None

## D.6. Medicaid Program New Initiatives: Behavioral Health Pilot Programs

- The state’s Behavioral Health Transformation 1115 waiver permits the state to implement pilot programs for a number of services. The pilots include enrollment limits.
- The pilots below are currently operational. The other five pilots are still in development; for tentative design plans, see next slide.

Pilot	Eligible Population	Demonstration Year 3 Enrollment Limits	Start Date
Residential and inpatient treatment in IMDs	Individuals with a primary diagnosis of addiction who meet the level of care need for residential/ inpatient treatment	None	February 2019
Clinically managed residential withdrawal management	Individuals with a primary diagnosis of addiction with moderate withdrawal symptoms	11,072	February 2019
SUD case management	Individuals with addiction who qualify for diversion into treatment from the criminal justice system	2,835	February 2019
Peer recovery support services	Individuals receiving addiction treatment	240	February 2019
Intensive in-home pilot	Children ages 3-21 with serious emotional disturbance at-risk of inpatient psychiatric admission and crisis service use	18,650	October 2018

## D.6. Medicaid Program New Initiatives: Behavioral Health Pilot Programs

Pilot	Eligible Population
Crisis intervention	Individuals ages 6-64 experiencing a psychiatric crisis
Evidence-based home visiting	Mothers 60-days postpartum who gave birth to children with withdrawal symptoms and Medicaid eligible children up to five years of age who were born with withdrawal symptoms
Assistance in community integration	Individuals with two or more chronic conditions with repeated emergency department or hospital admissions who are homeless or at-risk of institutional placement
Supported employment services	Individuals with serious mental illness or addiction disorder with functional limitations
Respite services	Children ages 3-21 with serious emotional disturbance at-risk of inpatient psychiatric admission and crisis service use

# E. Dual Eligible Financing & Service Delivery System

# E.1. Dual Eligible Medicaid Financing & Service Delivery System

<b>Dual Eligible* Medicaid System Characteristics</b>			
<b>Characteristics</b>	<b>Medicaid Fee-For-Service (FFS)</b>	<b>Managed Care-MLTSS Only</b>	<b>Medicare-Medicaid Alignment Initiative (MMAI) Dual Eligible Demonstration</b>
<b>Enrollment (January 2023)</b>	204,467	27,647	86,047
<b>Estimated SMI Enrollment</b>	65,429	8,847	27,535
<b>Management</b>	Department of Healthcare and Family Services	<ul style="list-style-type: none"> <li>Physical health: Department of Healthcare &amp; Family Services</li> <li>LTSS &amp; Behavioral Health: Six health plans</li> </ul>	Five health plans
<b>Payment Model</b>	FFS	<ul style="list-style-type: none"> <li>Physical health: FFS</li> <li>LTSS &amp; Behavioral Health: Capitated rate</li> </ul>	Blended capitated rate
<b>Geographic Service Area</b>	Statewide	Statewide as of July 1, 2019	Greater Chicago and Central Illinois regions

**Total Dual Eligible Enrollment: 318,161 | Total Dual Eligible Enrollment With SMI: 101,811**

\*Unless otherwise noted, the term *dual eligibles* in this section refers Medicare enrollees with full Medicaid benefits.

## E.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	January 2023 Enrollment	Estimated SMI Enrollment
Blue Cross Blue Shield of Illinois	Health Care Service Corporation	Medicare-Medicaid Alignment Initiative (MMAI)	21,622	6,919
MeridianComplete	Meridian Health Plan*	MMAI	18,316	5,861
Molina Dual Options	Molina Healthcare, Inc	MMAI	15,801	5,056
Humana Health Plan	Humana, Inc	MMAI	15,412	4,931
Aetna Better Health	Aetna/ CVS	MMAI	14,896	4,766

Note: Illinois does not have any D-SNP or PACE plans.

\*Meridian Health is operated by Meridian Health Plan which is owned by Wellcare/Centene

## E.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- Dual eligible enrollment as of January 2023 was 318,616.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers long-term services or supports (LTSS) and non-physician behavioral health services.
- Beginning July 1, 2019, dual eligibles in need of LTSS were required to enroll in Illinois HealthChoice, the state's Medicaid managed care program for LTSS and behavioral health services.
- Dual eligibles, regardless of need for LTSS, have the option to enroll in the Medicare-Medicaid Alignment Initiative (MMAI) if they live in a demonstration county.

## E.3. Dual Eligible Medicaid Financing & Delivery System: HealthChoice Illinois MLTSS Overview

- On July 1, 2019, Illinois expanded the MLTSS program statewide.
- In order to receive services through Illinois HealthChoice, individuals must be:
  - Full benefit dual eligibles
  - Reside in a nursing facility; or
  - Enrolled in one of the following HCBS waivers: Supportive Living Program, Persons with Disabilities, Persons with HIV or AIDS, Persons with Brain Injury, and Persons who are Elderly.
  - Individuals in the Breast and Cervical Cancer program are excluded from the program.
- All Illinois HealthChoice health plans will provide the MLTSS benefit package. For more information on the health plans see [section D.3](#).
- Humana and Aetna, which participate in the dual demonstration only, will not offer the HealthChoice Illinois MLTSS benefit package.

### HealthChoice Illinois MLTSS Benefits Package

1. Mental health rehabilitation option services
2. Alcohol and substance abuse rehabilitation services
3. Mental health targeted case management
4. Exceptional care
5. Non-emergency medical transportation
6. Social work services
7. Psychologist services
8. Skilled and intermediate long-term care
9. Licensed clinical professional counselor
10. Homemaker
11. Agency provided nursing therapies
12. Adult day health
13. Habilitation services
14. Respite care

## E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- On July 1, 2019, the state enrolled dual eligibles in need of LTSS in the Illinois HealthChoice program statewide.
- On February 22, 2013, Illinois and CMS signed a memorandum of understanding (MOU) for the Medicare-Medicaid Alignment Initiative (MMAI), and the state began enrolling dual eligible recipients in March 2014.
  - The state approved a three-year extension of the MMAI demonstration through December 31, 2022.
  - Other provisions include:
    - Increasing the aggregate savings percentage applied to the Medicare and Medicaid capitation rates to 6% for Demonstration years 6, 7, and 8.
- In August 2022, Illinois Governor JB Pritzker along with the Department of Healthcare and Family Services (HFS) launched the Program of All-Inclusive Care for the Elderly (PACE) for adults age 55 and older who qualify for both Medicare and Medicaid and need nursing home-level care.
- HFS selected eight organizations in five service areas, as partners in providing these new services to seniors in their region once they pass a stringent application with federal partners as well. The five service areas are West Chicago, South Chicago, Southern Cook County, Peoria, and East St. Louis.
- The grantees for each area are as follows:
  - West Chicago: Kinship PACE of Illinois, LLC; Lawndale Christian Health Center; and PACE of Southwest Chicago, LLC
  - South Chicago: Annie's Place PACE, and Esperanza Health Centers
  - Southern Cook County: BoldAge PACE Illinois
  - Peoria: OSF Healthcare System; East St. Louis: Stella PACE at Home, LLC
- The PACE providers are anticipated to begin providing services to Illinois seniors in state fiscal year 2024, joining 31 other states that currently have operational PACE programs. The existing programs serve an estimated 60,000 participants nationwide.

# E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

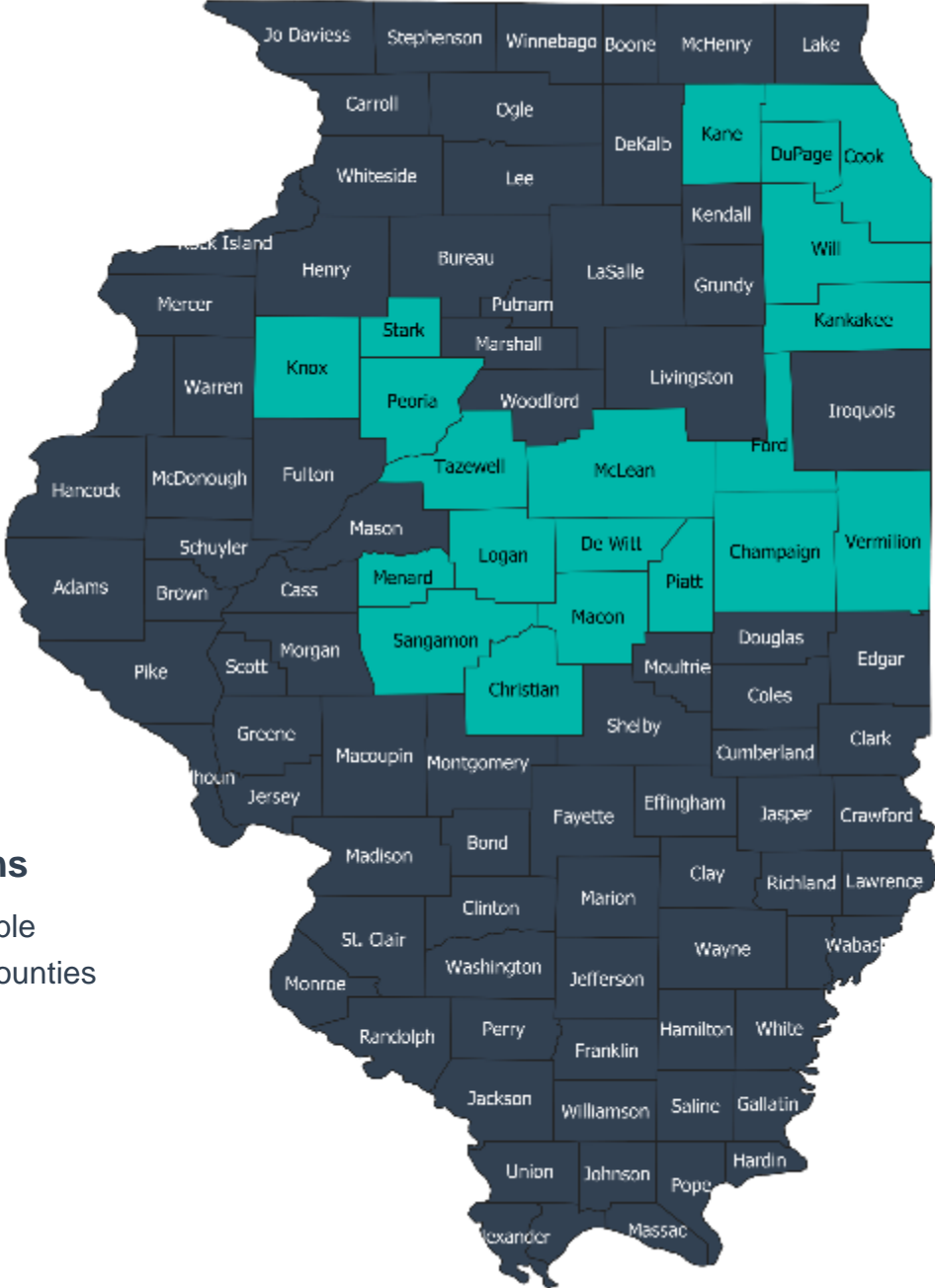
Medicare-Medicaid Alignment Initiative Dual Eligible Demonstration Overview	
<b>Target Population</b>	<ol style="list-style-type: none"> <li>1. Persons dually eligible for Medicare and Medicaid with full benefits, ages 21 and over</li> <li>2. Enrolled in the aged, blind, and disabled Medicaid assistance category</li> <li>3. Includes individuals receiving most 1915 (c) waiver services including:               <ul style="list-style-type: none"> <li>• Persons who are elderly</li> <li>• Persons with disabilities</li> <li>• Persons with HIV/AIDS</li> <li>• Persons with brain injury</li> <li>• Persons residing in Supportive Living Facilities</li> </ul> </li> <li>4. Excludes individuals receiving developmental disability waiver or institutional services</li> <li>5. 61,543 enrollees as of February 2021</li> </ol>
<b>Geographic Service Area</b>	<ul style="list-style-type: none"> <li>• Greater Chicago service region</li> <li>• Central Illinois service region               <ul style="list-style-type: none"> <li>• On July 1, 2019, the demonstration was reinstated in Christian, Logan, Macon, Menard, Piatt, and Sangamon counties, which is considered part of the central region.</li> <li>• On January 1, 2021, the demonstration was expanded to include new counties (see <a href="#">slide 51</a> for more information).</li> </ul> </li> </ul>
<b>Enrollment Model</b>	<ul style="list-style-type: none"> <li>• Passive enrollment with the ability to opt-out in the Greater Chicago service region</li> <li>• Opt-in in the Central Illinois service region because only one MMAI plan is available (Molina Healthcare)</li> <li>• Dual eligible individuals requiring LTSS must enroll in either MMAI or managed care to receive LTSS</li> </ul>
<b>Care Delivery Model</b>	<ul style="list-style-type: none"> <li>• Interdisciplinary care team with care coordinator</li> <li>• Integration of physical, behavioral health, and LTSS whenever possible</li> <li>• Management of transitions between levels of care</li> <li>• Care plan within 90 days of enrollment</li> </ul>

# E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

Medicare-Medicaid Alignment Initiative Dual Eligible Demonstration Overview	
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Acute care services</li> <li>• Pharmacy services</li> <li>• Behavioral health services</li> <li>• LTSS, including HCBS and skilled nursing facilities</li> <li>• Excludes forensic commitment in a state psychiatric hospital</li> </ul>
<b>Payment Model</b>	<p>Three monthly capitation payments</p> <ul style="list-style-type: none"> <li>• From CMS: One payment for Medicare parts A and B, and one payment for Medicare part D</li> <li>• From the state: One payment for Medicaid services</li> </ul>
<b>Practice Performance &amp; Improvement</b>	<ul style="list-style-type: none"> <li>• AHRQ, CAHPS, CMS, HEDIS, PQA, and state measures</li> <li>• Quality withhold payments equal 3% of both components of the blended capitated rate until the end of the program, which are proportionately returned if measure thresholds are met</li> <li>• Medicare part D payment is not subject to the quality withhold</li> </ul>

# E.4. Dual Eligible Medicaid Financing & Delivery System: MMAI Enrollment

MMAI Health Plan	January 2023 Enrollment	Estimated SMI Enrollment
Aetna Better Health	14,896	4,766
Blue Cross/Blue Shield of Illinois	21,622	6,919
Humana Health Plan	15,412	4,931
Meridian Health Plan	18,316	5,861
Molina Healthcare	15,801	5,056
<b>Total – All Regions</b>	<b>86,047</b>	<b>27,650</b>



### MMAI Regions

- MMAI Available
- Non-MMAI counties

# F. Long-Term Services & Supports Financing & Service Delivery System

# F.1. LTSS Financing & Service Delivery System

<b>LTSS* Medicaid System Characteristics</b>	
<b>Characteristics</b>	<b>Medicaid Managed Care</b>
<b>Enrollment (December 2022)</b>	61,543
<b>Estimated SMI Enrollment</b>	19,693
<b>Management</b>	LTSS & Behavioral Health: Five health plans
<b>Payment Model</b>	LTSS & Behavioral Health: Capitated rate
<b>Geographic Service Area</b>	Statewide as of July 1, 2019

\*Long-Term Services & Supports

## F.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory Managed Care Enrollment
Disabled adults			X
Disabled children			X
Blind individuals			X
Aged individuals			X
Dual eligibles		Individuals not requiring LTSS services and also reside in a dual eligible demonstration regions.	Individuals requiring LTSS services are required to enroll in managed care
Individuals with I/DD			X
Individuals residing in nursing homes			X
Individuals residing in ICF/IDD			X
Other HCBS Recipients			X
Other populations	<ul style="list-style-type: none"> <li>Limited benefits enrollees</li> <li>Individuals with third-party coverage</li> <li>Individuals eligible through spend-down</li> <li>Incarcerated or forensically institutionalized individuals</li> </ul>	<ul style="list-style-type: none"> <li>Alaskan natives</li> <li>American Indigenous Peoples</li> </ul>	

## F.2. LTSS Medicaid Financing & Delivery System: Overview

- On July 1, 2019, Illinois expanded the MLTSS program statewide.
- In order to receive services through Illinois HealthChoice, individuals must be:
  - Full benefit dual eligibles
  - Reside in a nursing facility; or
  - Enrolled in one of the following HCBS waivers: Supportive Living Program, Persons with Disabilities, Persons with HIV or AIDS, Persons with Brain Injury, and Persons who are Elderly.
  - Individuals in the Breast and Cervical Cancer program are excluded from the program.
- All Illinois HealthChoice health plans must provide the MLTSS benefit package. For more information on the health plans see [section D.3](#).
- Humana and Aetna, which participate in the dual demonstration only, chose not to offer the HealthChoice Illinois MLTSS benefit package.

# F.3. Medicaid LTSS Program: Health Plan Characteristics

Aetna Better Health
1. Profit status: For-profit
2. Parent company: Aetna/ CVS
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: CVS Caremark
5. Managed care programs: Medicare-Medicaid Alignment Initiative (MMAI), HealthChoice Illinois
6. Cook County only: No
7. Enrollment share: 15%

Blue Cross Blue Shield Of Illinois
1. Profit status: Non-profit
2. Parent company: Health Care Service Corporation
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager: Prime Therapeutics
5. Managed care programs: HealthChoice Illinois, MMAI
6. Cook County only: No
7. Enrollment share: 24%

CountyCare Health Plan
1. Profit status: Non-profit
2. Parent company: Cook County Health and Hospitals System
3. Behavioral health subcontractor: None
4. Pharmacy benefits manager:
5. Managed care programs: HealthChoice Illinois
6. Cook County only: Yes
7. Enrollment share: 14%

# F.3. Medicaid LTSS Program: Health Plan Characteristics

Meridian Health Plan Of Illinois	
1.	Profit status: For-profit
2.	Parent company: Centene-WellCare
3.	Behavioral health subcontractor: Cenpatico
4.	Pharmacy benefits manager: MeridianRx
5.	Managed care programs: HealthChoice Illinois, MMAI
6.	Cook County only: No
7.	Enrollment share: 34%

Molina Healthcare of Illinois	
1.	Profit status: For-profit
2.	Parent company: Molina
3.	Behavioral health subcontractor: None
4.	Pharmacy benefits manager: None
5.	Managed care programs: HealthChoice Illinois, MMAI
6.	Cook County only: No
7.	Enrollment share: 12%

## F.4. Medicaid LTSS Program: Health Benefits

### HealthChoice Illinois MLTSS Benefits Package

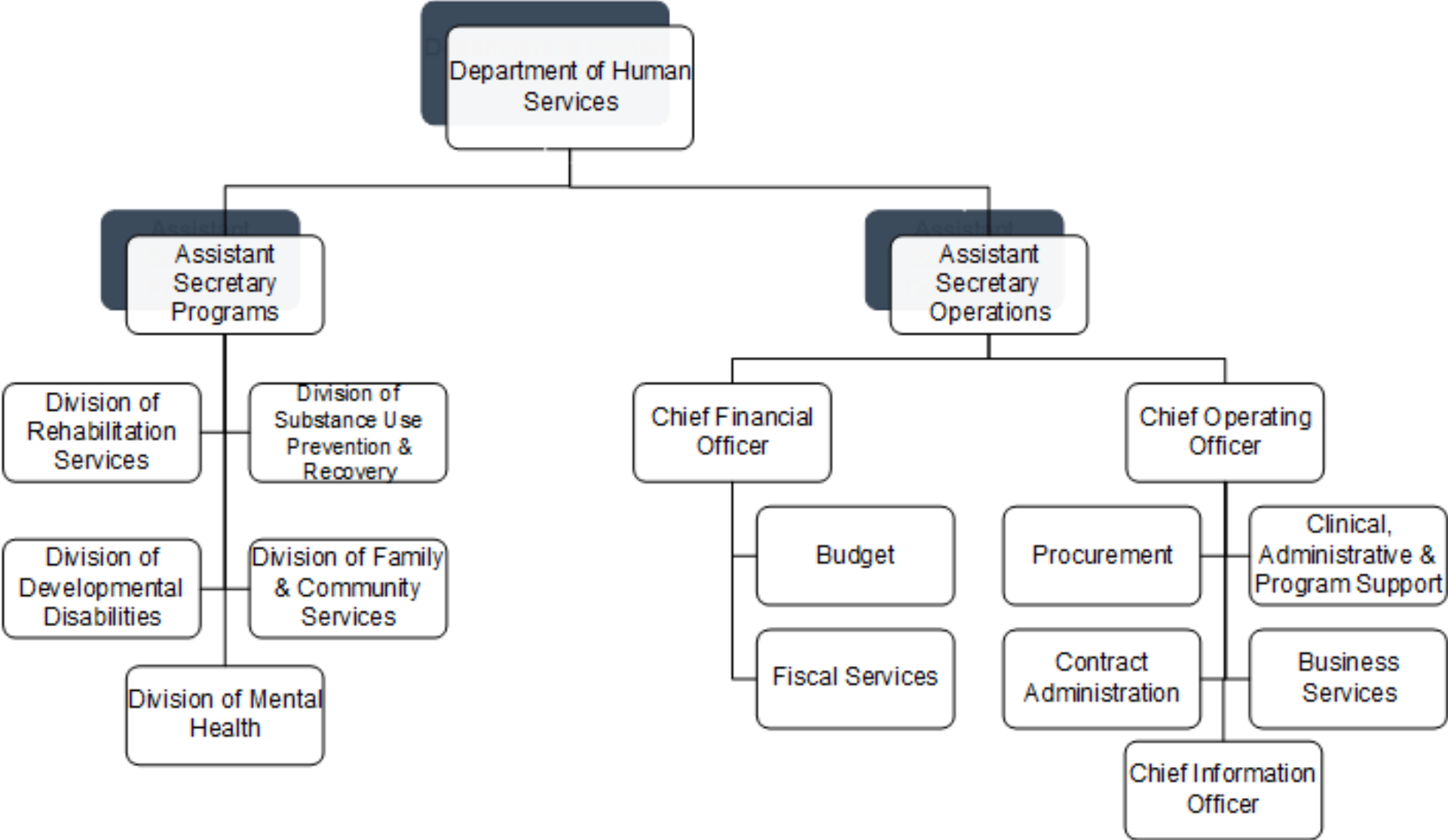
1. Mental health rehabilitation option services
2. Alcohol and substance abuse rehabilitation services
3. Mental health targeted case management
4. Exceptional care
5. Non-emergency medical transportation
6. Social work services
7. Psychologist services
8. Skilled and intermediate long-term care
9. Licensed clinical professional counselor
10. Homemaker
11. Agency provided nursing therapies
12. Adult day health
13. Habilitation services
14. Respite care

## F.5. LTSS Medicaid Financing & Delivery System: New Initiatives

- The Illinois Department of Human Services (IDHS) is launching an initiative to transform care for individuals with intellectual and developmental disabilities (I/DD) who live at one of the state's developmental centers. To support the transformation, in his budget proposal for fiscal year 2023-2023, Governor J.B. Pritzker increased funding for the IDHS home- and community-based system by \$800 million, bringing IDHS total funding to \$1.7 billion.
- The initiative will initially focus on the Choate Mental Health and Developmental Center (Choate). IDHS will expand community-based capacity statewide with the goal of reducing the number of developmental center residents, and will work to improve staffing ratios for those who remain at the developmental centers. The comprehensive plan includes:
  - Repurposing Choate over three years in partnership with the Southern Illinois University School of Medicine.
  - Implementing new safety enhancements at Choate and across all State-Operated Developmental Centers including appointing a Chief Resident Safety Officer.
  - Expanding support for transitioning families and individuals to pursue opportunities for community-based living while continuing to invest in provider organization capacity.
- To repurpose Choate, most of the approximately 233 current I/DD residents at the Choate Center in Anna, Illinois will have the opportunity to safely and gradually transition into community-based settings or other state centers where they will receive comprehensive personalized care. As I/DD residents transition, IDHS will repurpose the Choate campus to serve other populations. Currently, the IDHS Division of Mental Health operates a small psychiatric facility on the Choate campus.

# G. State Behavioral Health Administration & Finance System

# G.1. Department Of Human Services: Organization Chart



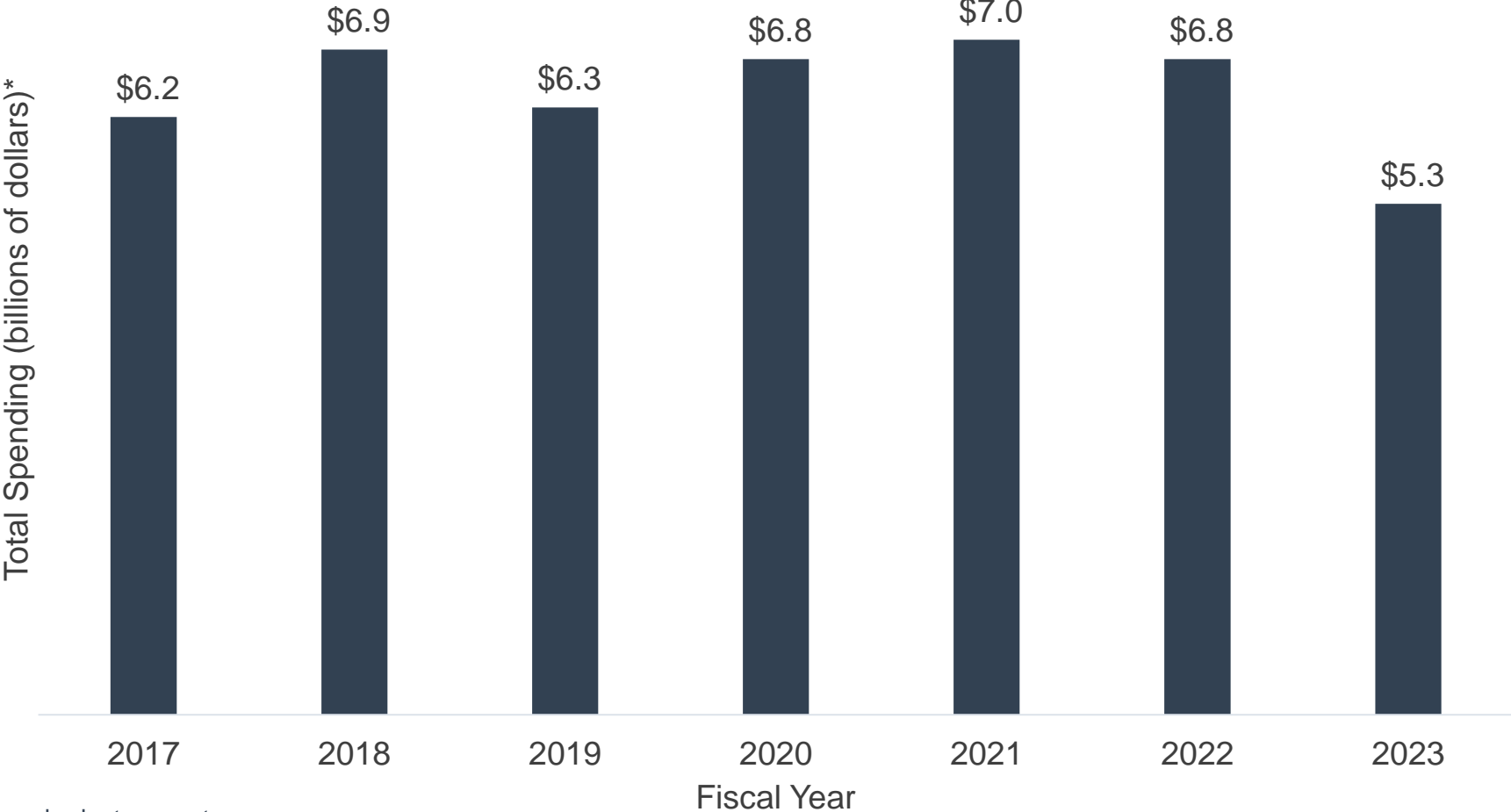
## G.1. Department Of Human Services: Key Leadership

Name	Position	Department	Email
Grace B. Hou	Secretary	Department of Human Services (DHS)	grace.hou@illinois.gov
Vacant	Assistant Secretary of Programs	DHS	N/A
Laura Garcia	Director	Division of Substance Use Prevention and Recovery	Laura.garcia@illinois.gov
David Albert	Director	Division of Mental Health	david.albert@illinois.gov
Tim Verry	Director	Division of Family and Community Services	tim.verry@illinois.gov
Rahnee Patrick	Director	Division of Rehabilitation Services	rahnee.patrick@illinois.gov

## G.2. Department Of Human Services: Spending

Budget Item	SFY 2023 Budget Request	Percent Of Budget
Family and community services	\$2,032,777,800	38%
Developmental disability services	\$2,040,509,300	38%
Mental health services	\$472,823,000	9%
Substance use prevention and recovery	\$452,042,700	8%
Mental Health Centers	\$300,626,300	6%
Administration	\$ 62,521,000	1%
<b>Budget Total: \$5,361,300,100</b>		

# G.2. Department Of Human Services: Spending Over Time



\*All years budget request

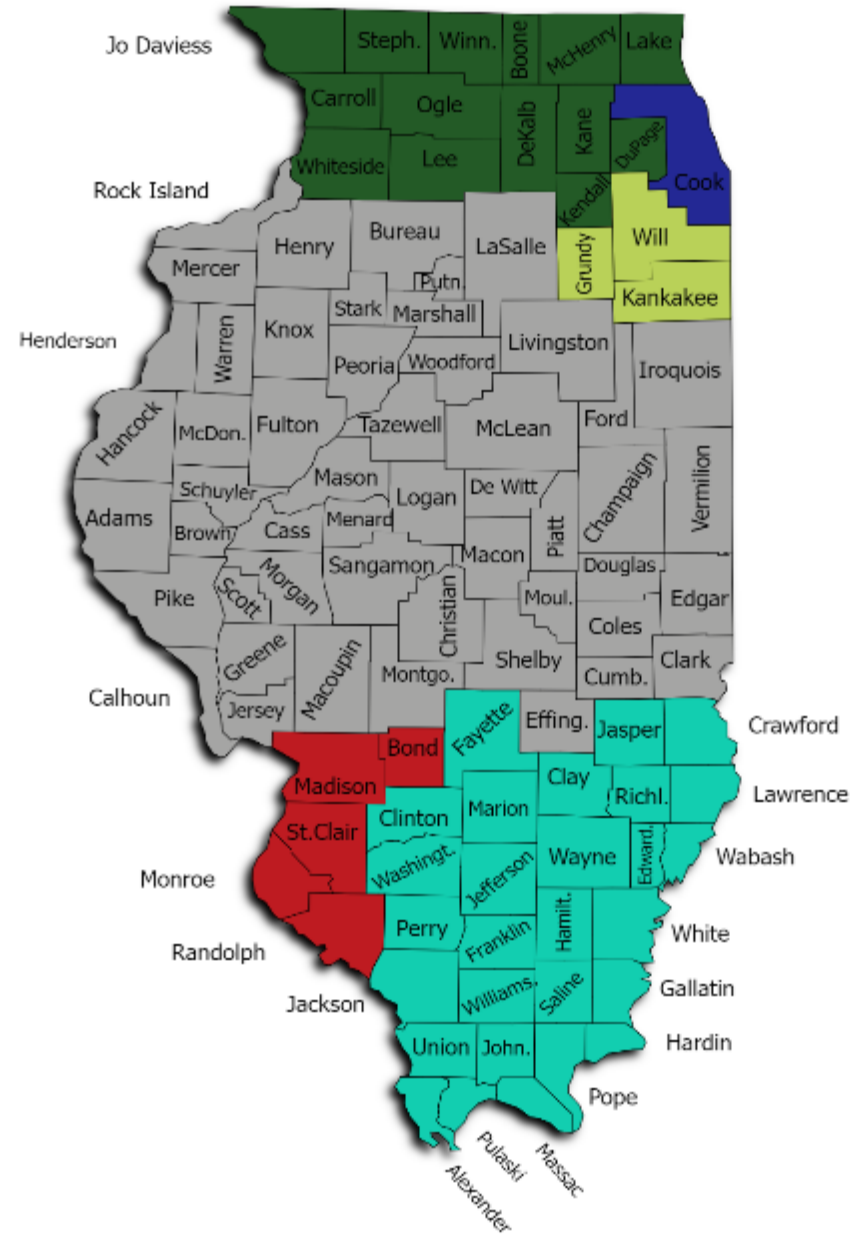
## G.3. State Psychiatric Institutions

State Psychiatric Institutions				
Institution	Location	Beds	FY 2022 Unduplicated Persons Served	June 20,2022 Census
Alton Mental Health Center	Alton	125	197	101
Chester Mental Health Center	Chester	302	518	279
Chicago-Read Mental Health Center	Chicago	148	274	138
Choate Mental Health Center (includes I/DD)	Anna	79	353	268
Elgin Mental Health Center	Elgin	419	799	367
Madden Mental Health Center	Hines	173	1,544	88
McFarland Mental Health Center	Springfield	146	255	121
<b>Total</b>		<b>1,392</b>	<b>3,940</b>	<b>1,362</b>

# G.3. State Psychiatric Institutions

## State Psychiatric Institution Catchment Areas

- Elgin Mental Health Center
- McFarland Mental Health Center
- Madden Mental Health Center
- Choate Mental Health Center
- Chicago-Read Mental Health Center
- Alton Mental Health Center



## G.4. Behavioral Health Safety-Net Delivery System

- The Illinois Department of Human Services (DHS) Division of Mental Health (DMH) contracts with community mental health centers and agencies to provide mental health services to the safety-net population.
- The Illinois Mental Health Collaborative, operated by Beacon Health Options, is the administrative services organization that provides utilization management, manages provider contracting, and produces reports for safety-net services.
- DHS is also the agency responsible for funding and administering addiction treatment programs for the safety-net population.
- Within DHS, the Division of Alcoholism and Substance Abuse (DASA) contracts with community-based organizations to maintain a statewide addiction treatment safety-net.

# H. Appendices

## H.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
<b>Commercial</b>	4.1% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from <a href="https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip">https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip</a>
<b>Medicaid</b>	8.6% of individuals enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from <a href="https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip">https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip</a>
<b>Medicare</b>	16% of persons in the Medicare population, not dually eligible for Medicaid	Centers for Medicare and Medicaid Services. (2021). Medicare-Medicaid Coordination Office Report to Congress. Retrieved January 2023 from <a href="https://www.cms.gov/files/document/mmco-report-congress.pdf">https://www.cms.gov/files/document/mmco-report-congress.pdf</a>

## H.1. OPEN MINDS Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	25% of persons in the Medicare population dually eligible for partial Medicaid benefits	Congressional Budget Office. (2013, June). Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spends, and Evolving Policies. Retrieved December 2022 from <a href="https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf">https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf</a>
	32% of persons in the Medicare population dually eligible for full Medicaid benefits	U.S. Department of Health and Human Services. (2019, May 9). Analysis of Pathways to Dual Eligible Status: Final Report. Retrieved December 2022 from <a href="https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report">https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report</a>
Other Public	5.6% of persons served by the Veterans Administration health care system or the TRICARE military health system	Military Health Systems. (2020, August). Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Report Processes. Retrieved December 2022 from <a href="https://www.health.mil/Reference-Center/Presentations/2019/11/04/Examination-of-Mental-Health-Accession-Screening-Update">https://www.health.mil/Reference-Center/Presentations/2019/11/04/Examination-of-Mental-Health-Accession-Screening-Update</a>
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 2022 from <a href="https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip">https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip</a>

## H.2. Glossary Of Terms

Term	Abbreviation	Definition
<b>Alternative Benefit Plan</b>	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
<b>Accountable Care Organizations</b>	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
<b>Administrative Services Organization</b>	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
<b>Capitation</b>		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
<b>Carve-out</b>		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
<b>Certified Community Behavioral Health Clinic</b>	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

## H.2. Glossary Of Terms

Term	Abbreviation	Definition
<b>Community Mental Health Center</b>	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(l) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC’s mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
<b>Dual Eligible</b>		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
<b>Federal Poverty Level</b>	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2023, the FPL is \$13,590 for an individual and \$27,750 for a family of four.
<b>Fee-For-Service</b>	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit-by-unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
<b>Health Home</b>		A “whole person” care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

## H.2. Glossary Of Terms

Term	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

## H.2. Glossary Of Terms

Term	Abbreviation	Definition
<b>Medicaid</b>		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
<b>Medicaid Waiver</b>		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
<b>Medicaid Waiver Section 1115</b>	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
<b>Medicaid Waiver Section 1915(b)</b>	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
<b>Medicaid Waiver Section 1915(c)</b>	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
<b>Medical Home</b>		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
<b>Medicare</b>		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
<b>Medicare Advantage</b>	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

## H.2. Glossary Of Terms

Term	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

## H.2. Glossary Of Terms

Term	Abbreviation	Definition
<b>Primary Care Case Management</b>	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination and is reimbursed fee-for-service for all medical services provided.
<b>Program Of All Inclusive Care For The Elderly</b>	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
<b>Serious Mental Illness</b>	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
<b>Supported Employment</b>		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment and retain that employment.
<b>Supported Housing</b>		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
<b>Value-Based Reimbursement</b>	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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