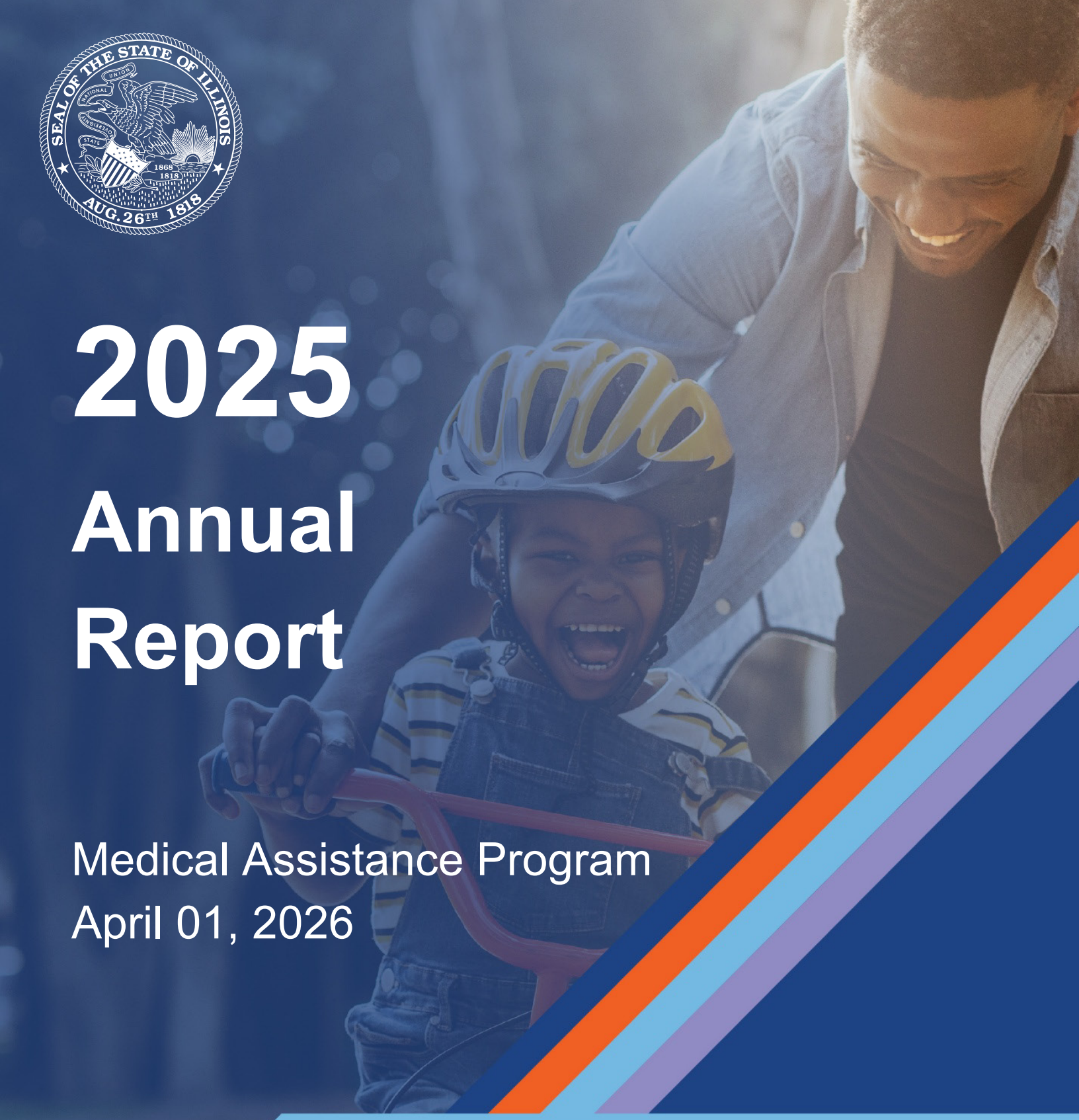


2025 Annual Report

Medical Assistance Program
April 01, 2026

JB Pritzker, Governor | Elizabeth M Whitehorn, HFS Director

HFS
Illinois Department of
Healthcare and Family Services

Letter From the Director

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

On behalf of the Illinois Department of Healthcare and Family Services (HFS), I am pleased to present the Fiscal Year (FY) 2025 Medical Assistance Programs Annual Report, describing our achievements in providing quality and accessible healthcare to the residents of Illinois.

During FY 2025, the Medicaid program marked its 60th anniversary – 6 decades of providing high-quality, essential healthcare coverage to millions of Illinois residents. As the state's largest health insurer, Illinois Medicaid now covers roughly 1 in every 4 Illinoisans and plays a vital role in sustaining the healthcare system in every region of the state. FY 2025 celebrated meaningful progress, including expanded access and improved services for the individuals and families who rely on us.

Key Achievements in FY 2025

- **Medical Debt Relief.** HFS launched the first statewide medical debt buyback program. This initiative relieved $345 million in medical debt for nearly 270,000 Illinoisans during the fiscal year and continues doing so, now surpassing more than $1 billion in relief. The program provides relief to hundreds of thousands of Illinoisans in all 102 counties of the state. Initial analysis demonstrates that people who have received relief had on average over $1,200 in debt eliminated - with some individual patients benefitting from tens or hundreds of thousands in relief, including one individual receiving $300,000 in debt relief.
- **Improved Access and Services.** HFS announced and initiated several new programs to tailor care and services that meet the needs of our customers. Among these:
    - The Department was accepted into the Centers for Medicare & Medicaid Services (CMS) Innovation Center's Cell and Gene Therapy (CGT) Access Model. The Model includes outcomes-based payment arrangements for 2 new sickle cell disease CGTs and is focused on increasing Medicaid customers' access to emerging and innovative treatments to improve health outcomes and reduce healthcare costs to state Medicaid programs.
    - Illinois was selected to participate in the federal Certified Community Behavioral Health Clinic (CCBHC) Medicaid Demonstration model, expanding access to integrated mental health and substance use treatment

services and allowing HFS to invest approximately $150 million more in the behavioral health system.

  - HFS and the Illinois Capital Development Board awarded 13 organizations a combined $200 million through the Healthcare Transformation Capital Investment Grant Program to support capital projects to address health-related social needs and reduce health disparities in historically underserved communities.

- **Maternal Health.** HFS continued to focus on improving care and reducing health disparities in maternal health outcomes.

  - HFS implemented new coverage for perinatal doula and lactation consultant services, increasing access to community-based care. This coverage includes standing recommendations from the Illinois Department of Public Health, reducing administrative paperwork for providers and Medicaid customers as they access these services.
  - Illinois was one of 15 states competitively selected to participate in the federal CMS Innovation Center's Transforming Maternal Health (TMaH) Model to develop a holistic, integrated approach to care from pregnancy through postpartum through pilot programs, provider partners, and federal grant funding in 2 areas of the state.
  - HFS partnered closely with the Medicaid Technical Assistance Center (MTAC) to support training and personal assistance for community-based maternal health providers enrolling in the Medicaid program for the first time.

Looking Ahead

In FY 2026, HFS is building on these accomplishments while also preparing for key Medicaid eligibility rule changes. A central focus will be minimizing potential harm to Illinois Medicaid customers resulting from the federal H.R. 1 law and ensuring clear, timely communication about what these changes mean for them. Throughout this work, HFS remains firmly committed to keeping eligible Medicaid customers covered and ensuring every Medicaid customer can access the care they need.

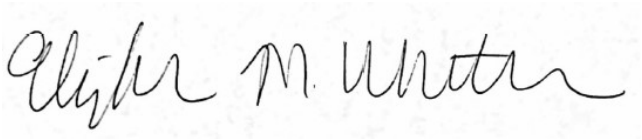
Amid federal budget cuts to rural healthcare, the Department will steward funds to support the state's rural healthcare infrastructure and drive sustainable change in underserved rural communities. Illinois was awarded $193.4 million for 2026 through the federal Rural Healthcare Transformation Program (RHTP) fund. While the federal RHTP fund will be far from enough to counteract the cuts imposed on the Medicaid program through H.R. 1, the RHTP will fund initiatives that help expand equitable access to healthcare and eliminate barriers to care that many residents of rural communities face. Each

RHTP initiative category has been informed by significant engagement with the rural health provider community.

Other key priorities for the coming year include major advancements within Illinois' managed care program, most notably the launch of the fully integrated dual eligible special needs plan (FIDE-SNP) and the comprehensive procurement of HealthChoice Illinois.

We look forward to continuing to work in partnership with the General Assembly and our stakeholders as we advance our mission.

Sincerely,



Elizabeth M. Whitehorn, Director

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Overview

MISSION

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

VISION

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

VALUES

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

WE IMPROVE LIVES.

The Illinois Department of Healthcare and Family Services (HFS) administers the medical assistance programs, including Medicaid, the Children's Health Insurance Program (CHIP), and state-funded coverage. Medicaid and CHIP coverage programs are jointly funded by the state and federal government and provide critical healthcare coverage to approximately 3.2 million individuals and families across Illinois.

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

Eligibility and Enrollment

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

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

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

Enrollment Numbers

The HFS Medical Assistance Programs serve as the largest health insurer in Illinois. In FY 2025, HFS provided medical coverage to more than 25% of the state's population. Program enrollment declined with the end of the COVID-19 Public Health Emergency (PHE), which included continuous enrollment requirements and temporarily suspended annual eligibility redeterminations Enrollment as of June 30 for the last 3 completed fiscal years (Illinois' fiscal year is July 1 to June 30) is as follows:

Comprehensive Benefits	FY 2023	FY 2024	FY 2025
Children	1,542,115	1,487,024	1,428,125
Adults with Disabilities	250,817	232,198	217,262
ACA Newly Eligible Adults	939,005	772,233	734,286
Other Adults	867,262	624,597	547,467
Seniors	336,269	295,617	288,272
Total Comprehensive	3,935,468	3,411,669	3,215,412
Partial Benefit Enrollees	46,499	51,204	48,410
Total Enrollees	**3,981,967**	**3,462,873**	**3,263,822**

Program Costs

During FY 2025, HFS spent approximately $38.98 billion (all funds), of which $27.73 billion was from the General Revenue Fund (GRF) or GRF-related funds for customer health benefits and related services. Please refer to Appendix IV for HFS FY 2025 spending by appropriation line.

Factors Impacting Program Costs

A summary of the factors contributing to the most significant changes in medical assistance program spending from FY 2023 – FY 2025 is provided below.

FY 2023

In FY 2023, enrollment continued to increase during the COVID-19 PHE by over 6.5%. The Health Benefits for Immigrant Adults & Seniors Program continued to enroll customers, which reflected in an increase within FFS claiming. Medicare Part D clawback increased due to CY 2023 rate and enrollment increases. One-time $490 million hospital stabilization and community mental health service payments were issued to providers.

FY 2024

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

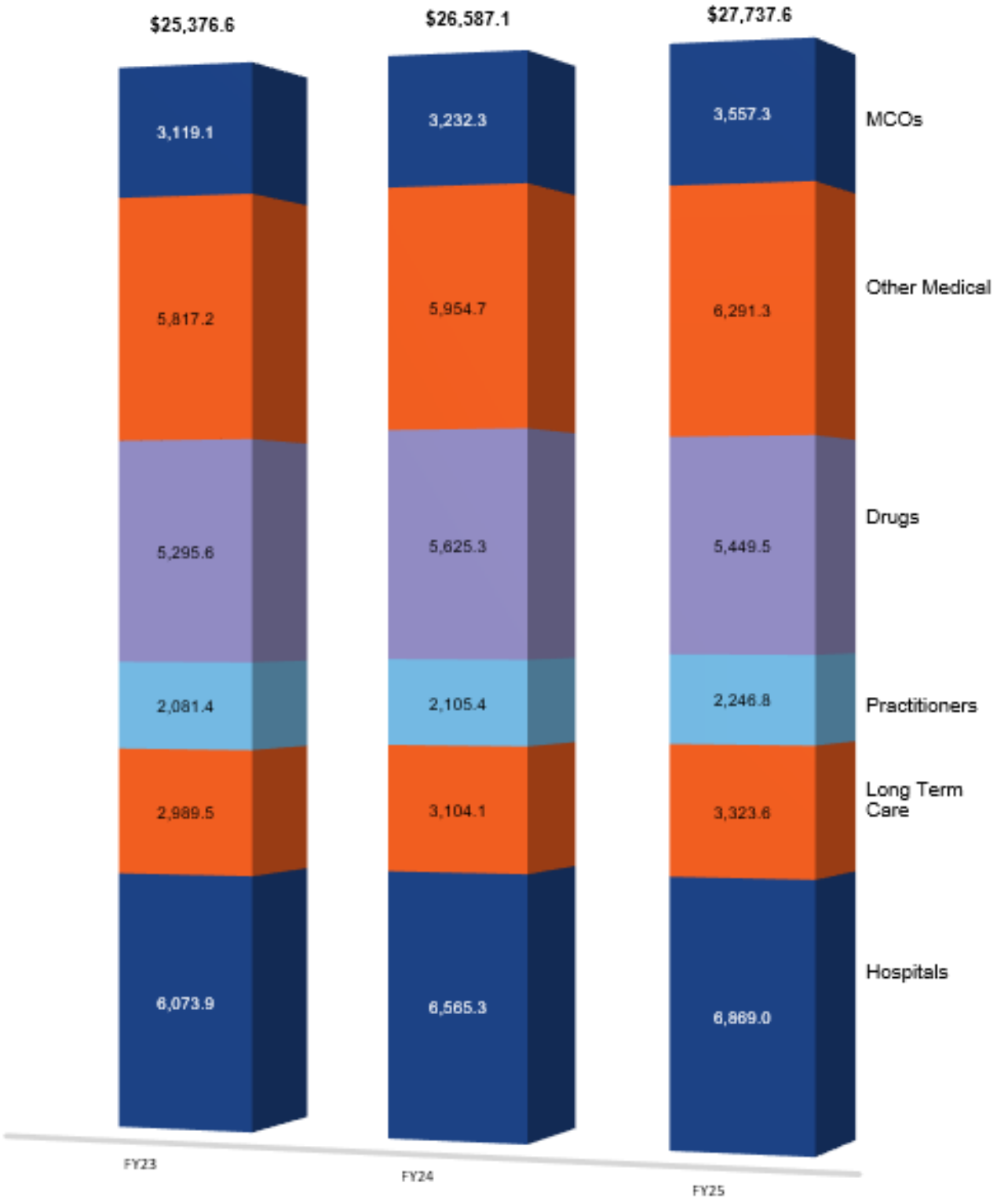
FY 2025

Redeterminations continued to take effect; however, increased acuity among the remaining population and inflationary factors continued to drive liability growth. Medicare Part D clawback increased due to the calendar year 2025 rate growth.

Medical Programs Spending

Fiscal Year 2023-Fiscal Year 2025

Dollars in Millions



Notes:

Not included in total spending are expenditures from the (Cook) County Provider Trust, University of Illinois Hospital Services, on-entitlements, Hospital Provider Fund (relating to the assessment), Trauma Center, Special Education Medicaid Matching, Money Follows the Person Budget Transfer, Electronic Health Record Incentive, Medicaid Buy-In, Medical Special Purposes Trust, Medical Interagency Program, Juvenile Rehabilitation Services, and Coronavirus Urgent Remediation Emergency Funds. MCOs includes administrative fees and approximately $1 billion in reimbursements to Medicaid MCOs for their portion of managed care assessment tax (cost of doing business) to effectuate federally required actuarily sound capitation rates. MCO capitations are generally allocated to provider types (Other Medical, Drugs, Practitioners, Long Term Care and Hospitals) based upon that fiscal years MCO encounter data. "Other Medical" refers to Laboratories, Transportation, Medicare A & B Premiums, Home Health Care/DSCC, Appliances, Other Related Supplies and Equipment, Community Health Centers Medically Complex Development (MCDD), and Hospice Care. Numbers may not appear to add due to rounding.

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Innovation

Transforming Illinois' Healthcare System Through Innovation

In FY 2025, HFS accelerated its work to reimagine how healthcare is delivered by championing innovative, equity-centered approaches that better meet the needs of the communities across the state. Guided by our agency's mission, HFS advanced new models of care, expanded non-traditional service delivery options, and invested in transformative strategies designed to close access gaps and improve outcomes, particularly for populations historically underserved by the healthcare system.

This section highlights some of the initiatives HFS and its partners are undertaking to build a more integrated and holistic system of care that improves the lives of Illinois Medicaid customers.

Transforming Maternal Health Model (TMaH)

In January 2024, HFS was selected by the federal Centers for Medicare & Medicaid Services (CMS) to participate in the new Transforming Maternal Health (TMaH) Model, a major national initiative designed to improve maternal health outcomes through a whole-person approach to care. The 10-year federal program will provide $17 million in critical funding to help HFS develop and pilot a more comprehensive and integrated approach to addressing physical health, mental health, and social needs throughout pregnancy, childbirth, and the postpartum period.

This investment will help build and pilot a comprehensive value-based payment model, strengthen provider infrastructure, and advance the state's commitment to achieving birth equity. With Medicaid covering nearly half of all births in Illinois, the TMaH Model represents a substantial opportunity to improve outcomes for pregnant and parenting people in underserved communities.

The TMaH Model will test a new paradigm of maternity care in 2 areas of the state by increasing access to and expanding the maternal health workforce while also increasing the use of comprehensive clinical and social screenings, risk-appropriate care, safety practices, and home monitoring. Its goals include reducing rates of low-birthweight infants, preventable low-risk cesarean deliveries, and severe maternal morbidity, while improving the overall experience of care. The framework is built around 3 pillars:

1. Expanding access, infrastructure, and workforce capacity;
2. Strengthening quality improvement and safety practices; and
3. Supporting whole-person, risk-appropriate care delivery.

Through the TMaH Model, HFS will gain valuable technical assistance and resources to invest with community-based providers to address existing gaps in maternal health care by increasing access to midwives, doulas, and lactation consultants, strengthening management of chronic

conditions such as diabetes and hypertension, reducing unnecessary C-sections, and addressing postpartum depression and anxiety. This work will be piloted in the Aurora and Rockford communities, which include diverse rural, suburban, and urban communities with persistent disparities in maternal health outcomes.

The Model has a 3-year pre-implementation period, which began in January 2025 and runs through December 2027. During this phase, Illinois is focusing on building the infrastructure necessary to support the full Model implementation, including technical assistance, workforce expansion, risk screening improvements, and development of payment and care-delivery reforms. These foundational efforts will prepare Illinois to successfully launch the TMaH Model in the pilot communities beginning in January 2028.

Improving Affordability and Access to High-Cost Drugs

Sickle cell disease (SCD) is a lifelong inherited blood disorder that disproportionately affects people of color—particularly Black Americans—and is associated with severe chronic complications and a life expectancy more than 20 years shorter than average. In December 2023, the U.S. Food and Drug Administration (FDA) approved 2 landmark gene therapies for SCD, Lyfgenia and Casgevy, marking a major advancement in treatment. However, as prices for these and similar cell and gene therapies (CGTs) often exceed $2 million per patient, the emergence of these therapies presents significant affordability and equity challenges for state Medicaid programs. Ensuring equitable access to transformative treatments for historically underserved populations remains a central priority for HFS.

Recognizing both the promise and the financial risks of these therapies, Governor Pritzker issued Executive Order 2024-01 in March 2024 directing HFS to develop innovative payment and financing models that support equitable access to SCD treatments and other high-cost drugs. The order also established the Advisory Council on Financing and Access to Sickle Cell Disease Treatment and Other High-Cost Drugs and Treatment, which met 6 times throughout 2024 and delivered its formal report to the General Assembly on January 2, 2025. The Advisory Council's recommendations to HFS included strategies for financing CGTs, improving equitable access, supporting care coordination, and building system capacity. Monitoring and implementing these recommendations will be ongoing.

A major theme of the Council's work was the need for innovative financing models that help states mitigate large upfront costs while ensuring access. The Council recommended, among other strategies, carving CGTs out of bundled hospital payments to ensure they qualify as "covered outpatient drugs" eligible for federal and supplemental rebates; exploring value-based and outcomes-based agreements; enhancing utilization management consistency across MCOs; and investing in wrap-around supports that address transportation, housing, childcare, and other barriers that disproportionately affect patients with SCD and other rare diseases.

These recommendations informed HFS's next steps during FY 2025. In spring 2025, HFS applied for and was accepted into the CMS Innovation Center's CGT Access Model, a federal initiative which tests whether CMS-negotiated outcomes-based agreements with drug manufacturers can improve access to CGTs, improve Medicaid customer outcomes, and reduce state Medicaid expenditures. Illinois will begin participation in the CGT Access Model on January 1, 2026, specifically for the 2 SCD gene therapies included in the Model—Lyfgenia and Casgevy. To support implementation of the CGT Access Model, HFS applied for and was awarded a federal grant in fall 2025. The grant funding will help support customer access to other wraparound and support services while undergoing treatment.

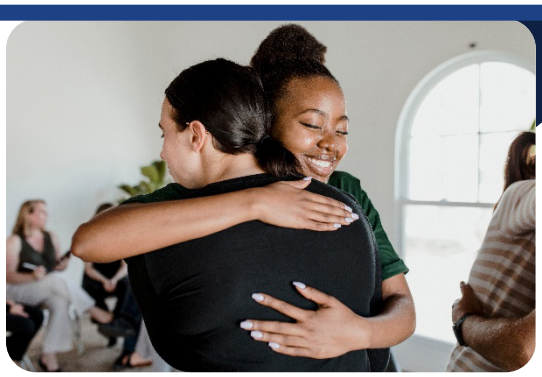
Additionally, to support participation and strengthen the state's purchasing position, HFS also submitted a State Plan Amendment to carve high-cost drugs out of bundled hospital payments, ensuring these therapies qualify for Medicaid drug rebates. This carve-out, which aligns with key recommendations from the Advisory Council, will take effect concurrently with Illinois' entry into the CGT Access Model on January 1, 2026.

HFS's acceptance into the federal Model represents a major milestone in the state's strategy to responsibly manage the financial implications of high-cost therapies while enhancing equitable access for Medicaid customers. Together with the Advisory Council's comprehensive set of 23 recommendations, these efforts reflect Illinois's leadership in modernizing Medicaid payment systems, strengthening supports for populations disproportionately affected by rare diseases, and ensuring that emerging transformative therapies are accessible to the individuals who need them most.

Certified Community Behavioral Health Clinics

In FY 2025, HFS advanced the implementation of the state's Certified Community Behavioral Health Clinic (CCBHC) initiative, in partnership with the Chief Behavioral Health Officer (CBHO) and the Illinois Department of Human Services' Division of Behavioral Health and Recovery (IDHS-DBHR). CCBHCs provide fully integrated behavioral health services—including mental health care, substance use treatment, primary care screening and monitoring, and 24/7 crisis intervention—to anyone who seeks care, regardless of age, residence, or ability to pay. To ensure comprehensive access, CCBHCs must deliver the following 9 core services:

1. Crisis Services
2. Outpatient Mental Health and Substance Use Services
3. Person-and-Family Centered Treatment Planning
4. Community-Based Mental Health Care for Veterans
5. Peer Family Support and Counselor Services
6. Targeted Care Management
7. Outpatient Primary Care Screening and Monitoring
8. Psychiatric Rehabilitation Services
9. Screening, Diagnosis and Risk Assessment



Keisha's Story

After arriving at the HRDI CCBHC a year ago, I was struggling with addiction, unmanaged health conditions, and deep personal loss. With the support of my counselor, I restarted my medications, began methadone treatment, and began attending counseling regularly. With HRDI's help, I have started to trust people again and feel better equipped to manage my triggers.

Today, my husband and I are both in recovery, and our relationship is better than ever. I enjoy waking up each day knowing that I do not have to worry about how or when I am going to get the high I once craved. I am 45 years old now and I have never cared more about my health or my life.

Illinois made significant progress in strengthening this model through its participation in the federal Section 223 CCBHC Medicaid Demonstration (Demonstration). After being selected in June 2024, Illinois launched Demonstration operations on October 1, 2024, with 19 state-certified CCBHCs. Under this model, participating providers receive a site-specific daily prospective payment system (PPS) rate for Medicaid services, calculated from the true cost of care. This represents a major shift from traditional fee-for-service payment, enabling long-term financial sustainability for clinics serving individuals with complex behavioral health needs. Between October 2024 and June 2025, participating CCBHCs were reimbursed $120.3 million, supporting expanded capacity, high-intensity services, and enhanced care integration.

To encourage broader access and continued statewide expansion, HFS announced it would be launching a structured Learning Collaborative. The Learning Collaborative, facilitated by the Medicaid Technical Assistance Center (MTAC) and supported by national subject matter experts from the National Council for Wellbeing, provides participating providers with technical assistance, training, and guidance on meeting federal CCBHC standards. Providers applied through a competitive process, with HFS prioritizing agencies located in geographic areas without an existing CCBHC to promote geographic equity in access to comprehensive behavioral health services.

In June 2025, HFS announced the selection of 10 providers to join the Learning Collaborative and begin the process towards becoming a state-certified CCBHC. Of these, 9 agencies completed the Learning Collaborative in early 2026 and are on track to achieve certification and enter the Demonstration by the end of FY 2027. This next cohort represents a significant expansion of the CCBHC network and reflects Illinois' ongoing commitment to ensuring that high-quality, integrated behavioral health services are available throughout the state.

Illinois Healthcare Transformation Section 1115 Demonstration Waiver

HFS strengthened its commitment to equitable healthcare by receiving federal approval on July 2, 2024, to extend the Illinois Healthcare Transformation Section 1115 Demonstration Waiver (previously called the Behavioral Health Transformation Section 1115 Demonstration Waiver) through June 30, 2029. The waiver continues existing substance use disorder (SUD) services and adds new supports to address housing, employment, medical respite, food and nutrition, violence prevention, non-medical transportation, and reentry for those transitioning from incarceration or institutions. These enhancements aim to deliver sustainable, community-driven care and include non-traditional providers in Medicaid.

In FY 2025, HFS has progressed with implementation planning for the Healthcare Transformation 1115 waiver. Federal CMS has approved key deliverables related to health-related social needs (HRSNs), including an operational protocol and implementation plan. HFS maintains active collaboration with providers, carceral partners, community-based organizations, managed care organizations, and stakeholders as it prepares for service rollout.

Healthcare Transformation Collaboratives: Partnerships for Community Innovation

In 2021, HFS launched the statewide Healthcare Transformation Collaboratives (HTC) initiative, which established integrated cross-provider networks of health and social service providers who collaborate on reducing care gaps and health disparities in their local communities. HTCs are at the forefront of embedding community health worker services into their community outreach, care coordination, patient education strategies, and integrating bi-directional navigation to social services and healthcare services.

In 2024, HFS provided more than $137 million in funding to 14 collaboratives across the state. Collectively that year, HTC providers employed or subsidized more than 850 personnel statewide, conducted more than 96,500 social determinants of health (SDOH) screenings and made more than 19,300 social care referrals, and provided more than 128,000 patient visits.

Spotlight: Wellness West

Through Wellness West, community health workers are being deployed across Chicago’s west side to integrate primary and specialty care while linking residents to social services. In 2024, partners conducted more than 33,000 health risk screenings and treat more than 17,000 residents. Preliminary analysis shows that customers being treated for diabetes or hypertension have achieved control at a higher rate than the statewide average, and that depression symptoms have dropped. Notably, a segment of customers provided permanent supportive

housing reduced their emergency department utilization with an estimated savings of $33,000 per customer.

Michael's Story

Michael started drinking at age 9 to cope with physical abuse at the hands of his father. He was admitted to inpatient treatment at Hartgrove Hospital for acute alcohol intoxication, depression, and suicidal thoughts. When he got out, Collaborative Bridges stepped in, finding him a primary care doctor, psychiatrist, and therapist. The collaborative kept providing case management, and today, Michael is flourishing in recovery and employed as a small machine repairman. He continues to keep his doctor appointments, crediting Collaborative Bridges with keeping him on track.

Healthcare Transformation Capital Investment Grant Program

The Healthcare Transformation Capital Investment Grant Program is a strategic initiative administered by HFS in partnership with the Illinois Capital Development Board (CDB) to strengthen and modernize the state's healthcare infrastructure. Building upon the HTC program, this capital initiative supports hospitals and community-based providers in constructing, renovating, and equipping facilities that expand access to essential health services—particularly in historically underserved and high-need communities.

In December 2024, HFS and CDB awarded 13 organizations a combined $200 million to advance major capital projects across Illinois. 9 of the 13 funded projects were tied to participating HTC entities, ensuring that capital resources directly supported collaborative, community-driven efforts to improve health equity. 6 awardees were safety-net health organizations, representing 48% of all funding. Safety-net providers deliver care regardless of a patient's insurance status or ability to pay, making these investments critical to maintaining access in communities that need it most.

The funded projects are accelerating the expansion of primary care, behavioral health, emergency services, and specialty care capacity statewide. Grantees are constructing new community health centers, building Certified Community Behavioral Health Clinics, expanding psychiatric and adolescent mental health units, modernizing emergency departments, and renovating aging clinical space to meet current standards of care.

Medical Debt Relief Program

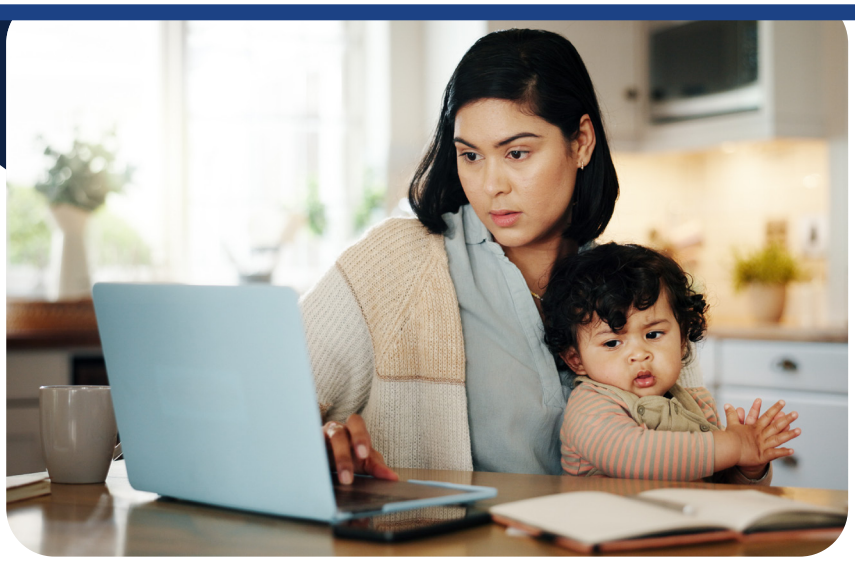
The Medical Debt Relief Program began on October 1, 2024, following passage of the Medical Debt Relief Act by the Illinois General Assembly. The law created a dedicated fund within the State's General Revenue Fund to purchase and eliminate medical debt for low-income Illinois residents. To qualify, an individual must be an Illinois resident with household income at or below 400% of the federal poverty level or have significant medical debt relative to their income.

The General Assembly appropriated $10 million to launch the program, and because medical debt can often be purchased for a fraction of its face value, these funds are expected to eliminate a substantially greater amount of debt overall. The program works by using State dollars to buy qualifying debt from hospitals and other providers or from secondary market debt collectors at a discounted rate, and then permanently retiring it.

Illinois is partnering with Undue Medical Debt, a national nonprofit that has worked with governments across the country, to facilitate the purchase and cancellation of eligible debt on the State's behalf. As of June 30, 2025, the program has relieved $363,058,646 in medical debt for 309,273 Illinois residents.

For Illinois residents, there is no application process and individuals cannot apply directly; instead, debt is identified and purchased in bulk from participating providers. Once relieved,

residents receive notification by mail. Participation by providers is voluntary, and the State cannot require hospitals or debt holders to sell debt into the program. As a result, some eligible residents may not benefit if their provider chooses not to participate. Ongoing outreach and coordination with providers make implementation a longer-term effort, but progress will steadily continue.



Kayla's Story

Debt Abolished: $1,769

Unfortunately, like many others, I had to go to the emergency room for help. I was experiencing stroke-like symptoms. I was terrified. I had, at the time, two young children. I shouldn't think about how much all of this would cost. I'm not going to lie, though, a small part [of me] did think of [the cost] and the burden it would cause for our family. In our financial situation, there was no way to pay it off within the 90 days the hospital gives before going to collections. The only option we had was through [a] payment plan, but it would take many years to pay it off. Sure enough, the debt went to collections. This action [stopped] me from even trying to apply for a house with my husband. It is so unbelievable. Why should medical debt play a part in what my future [will look] like? I shouldn't think about how to pay for an emergency visit. I should worry about having a roof and food for our family.

I want the donors to know that by helping me cancel my medical debt, it has helped me immensely emotionally, mentally, and financially. Thank you. I am forever grateful from the bottom of my heart.

3

Promoting Coverage and Affordability

Concluding the Medicaid Continuous Coverage Unwinding

In FY 2025, Illinois completed the COVID-19 Public Health Emergency (PHE) unwinding efforts, finalizing redeterminations for customers with renewal dates in the last months of the unwinding period. During the unwinding, Illinois experienced an eligibility retention rate of 76%, one of the highest in the nation. A major contributor to Illinois' strong performance, in addition to the statewide outreach campaign and adopted federal flexibilities, was the significant improvement in automated (ex parte) renewals. By late 2024, Illinois' ex parte rate reached approximately 70%, supported by targeted system and policy enhancements—including temporary federal approval to treat $0 income households as ex parte eligible through June 2025, integration of the Asset Verification System to increase ex parte determinations for AABD customers, and the transition from case level to individual level processing.

During FY 2025, the state's focus shifted from managing unprecedented renewal volumes to strengthening long-term operational stability. The improvements implemented during the unwinding—enhanced data-driven eligibility processes, expanded ex parte renewal pathways, and more effective customer support mechanisms—have now become embedded in routine operations. As Illinois returns to standard annual renewal cycles, these strengthened systems and supports position the Illinois Medical Assistance Program to sustain high retention, minimize administrative burden for both customers and staff, and maintain reliable coverage continuity for eligible Illinoisans.

Get Covered Illinois and Navigator Program

Public Act 103-0103 directs the Department of Insurance (DOI), in partnership with HFS, to establish a state-run health insurance marketplace.

Illinois is moving through a 2-phase implementation: operating as a State-Based Marketplace on the Federal Platform (SBM-FP) for Plan Year 2025 (CY25), beginning with open enrollment in fall 2024, and launching the fully state-run Get Covered Illinois (GCI) platform for Plan Year 2026 (CY26), with open enrollment beginning November 1, 2025. This marks Illinois' first departure from Healthcare.gov in more than a decade and represents a major shift toward a more customer-focused and locally responsive marketplace. The new system will enhance the state's ability to support individuals whose incomes place them just above Medicaid eligibility, improve transitions between Medicaid and Marketplace coverage for individuals whose income has changed, and better identify and serve communities with historically high uninsured rates.

A key component of this transition is the GCI Navigator Program, which provides grant funding to conduct year-round outreach, enrollment assistance, and education. Although the SBM is housed at DOI, HFS manages the financial components of the GCI Navigator Program and supports the statewide network of GCI Navigators—trusted community-based staff trained to assist with enrollment in both the marketplace and Medicaid. Navigators regularly engage with residents in community settings, including non-traditional locations such as laundromats, to ensure individuals can access accurate information and personalized help.

In October 2024, HFS and DOI announced that 5 healthcare organizations were awarded a total of $6.5 million in grants for Plan Year 2025. This close collaboration between HFS and DOI has streamlined grant operations, strengthened program oversight, and expanded the reach of enrollment assistance across the state.

As Illinois prepares for the full SBM launch in fall 2025, HFS and DOI continue to work closely to refine communication and outreach strategies, drawing lessons from prior marketplace transitions and other state models. These efforts will ensure the new Get Covered Illinois platform is accessible, customer-friendly, and equipped to connect eligible residents to affordable, high-quality health coverage. Through these coordinated activities, the state remains focused on reducing the number of uninsured Illinoisans.

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Access to Care

Improving Maternal and Infant Health

Illinois made significant progress in FY 2025 toward improving maternal and infant health outcomes and reducing longstanding racial disparities in birthing outcomes. A central focus this year was expanding access to supportive services that strengthen the continuum of perinatal care.

In December 2024, HFS implemented Medicaid coverage for both doula services and lactation consultant services. These services are now available without a physician referral due to the Illinois Department of Public Health's issuance of standing recommendations, removing a key access barrier for Medicaid customers and reducing administrative burden for providers. Together, these benefits offer Medicaid customers comprehensive physical, educational, and emotional support throughout pregnancy, childbirth, and the postpartum period, as well as skilled assistance for breastfeeding and lactation needs.

HFS also advanced efforts to expand and diversify the maternal health workforce by securing federal approval to enroll and reimburse Licensed Certified Professional Midwives (LCPMs) and Home Visiting Organizations as Medicaid providers. HFS has been actively working to implement Home Visiting Organization and LCPMs enrollment and covered services. Once implemented, home visitors will offer informational support, developmental screening, and care coordination to pregnant individuals, new parents, and young children. LCPMs will expand home birth opportunities throughout the state and, once they are implemented as a new Medicaid provider, will be eligible to receive quality incentive add-on payments for timely postpartum visits. These incentives are intended to increase early and continuous postpartum care, a critical period for preventing complications and improving maternal health outcomes.

Finally, HFS worked closely with partners to advance supportive legislation. The agency initiated and supported the Doula Medicaid bill enacted in the spring 2025 legislative session, ensuring hospitals and birthing centers allow Medicaid customers to be accompanied by a certified, Medicaid-enrolled doula of their choice to provide support before, during, and after labor and childbirth. The bill also ensures that doulas are considered part of the birthing parent's care team, prohibiting facilities from counting the doula against established visitor or guest limits.

HFS is also planning for additional maternal and child health provider types—including medical case workers and community health workers—to further strengthen the maternal health system. Collectively, these initiatives represent a comprehensive and equity-focused strategy to improve outcomes for parents and infants across Illinois.

Illinois Medicaid Preventive Care and Education Organization

Pursuant to Public Act 102-0699, HFS was tasked with the establishment and implementation of a Managed Primary Care Demonstration Project. In spring 2024, HFS released a Request for Application (RFA), seeking a Medicaid Preventive Care and Education Organization (MPCEO) with the goal of increasing Medicaid customers' ownership of their health and well-being by expanding healthcare knowledge, improving access to preventive services, and strengthening engagement with primary care providers and health plans.

Following the competitive selection process, HFS contracted with BigHeart Health to operate the MPCEO program, known publicly as "My Health. My Power." BigHeart is a Chicago-based digital health platform with extensive experience supporting preventive care engagement for Medicaid populations. Building on its existing infrastructure, BigHeart will deliver statewide preventive care education and outreach to more than 500,000 Medicaid members. The program will focus on increasing awareness of available preventive services, identifying gaps in care, coordinating care plans with providers, and connecting members to in-network primary and preventive care.

During FY 2025, BigHeart prepared to launch targeted outreach efforts in three priority regions: South Suburban Cook and Will Counties, Central Illinois, and Southern Illinois. Through coordinated communication with Medicaid members and partnership with Managed Care Organizations (MCOs) and in-network providers, the program will support timely scheduling of annual wellness visits and other preventive services, reinforcing HEDIS measures and addressing unmet preventive care needs. The MPCEO program is targeted to launch in January 2026.

Program of All-Inclusive Care for the Elderly

PACE Lawndale Christian Health Center

One of Lawndale Christian Health Center's (LCHC) earliest PACE participants enrolled shortly after turning 65 with multiple chronic conditions, a substance use disorder, mobility challenges, and several wounds. After an early overdose and emergency department visit, she agreed to begin medication assisted recovery (MAR) and engage in LCHC's recovery community.

Just 180 days later, she has made remarkable progress. She has reduced her need for MAR, healed all wounds with consistent support, and significantly improved her posture and mobility—now walking with minimal assistance. She has also avoided emergency department visits for nearly 6 months.

Her progress demonstrates the strength of the PACE model in supporting participants with complex medical and behavioral health needs and has been a true source of inspiration for the LCHC PACE team.

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

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

In 2023, after a competitive application process, HFS awarded PACE organizations in 5 service regions throughout the state (West Chicago, South, Chicago, Southern Cook County, Peoria, and East St. Louis). Three PACE organizations (Lawndale Christian Health Center, Esperanza Health Centers, and OSF HealthCare) began providing services in July 2024, while one additional organization (BoldAge PACE Illinois) began operations on November 1, 2024.

In FY 2025, PACE organizations served a total of 107 customers.

Provider Rate Increases

In FY 2025, HFS implemented more than $200 million in provider rate increases across various covered healthcare services with the goal of supporting increased access to care and stabilizing the Medicaid provider workforce. Key reimbursement increases include:

- **Children's Community-Based Health Care Centers.** Rates for transitional nursing care delivered by Children's Community-Based Health Care Centers were raised to $1,300 per day and are anticipated to result in an additional annual investment of $4 million into these services.
- **Pathways to Success Services.** Providers offering care coordination and other home and community-based services to children enrolled in the Pathways to Success program are estimated to receive an additional $22 million annually in reimbursement.
- **Safety-Net Hospitals.** $68 million was invested in increasing reimbursement to safety-net hospitals through adjustments to the low volume and tiered safety net add-on payments.
- **Long Term Care Facilities.** Nursing facilities are expected to receive an additional $52 million resulting from updates to STRIVE staffing, including a transition from RUGs to PDPM-based staffing ratios, and changed to the real estate tax component of rates. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and Medically Complex for the Developmentally Disabled (MC/DD) facilities received an estimated $22.1 million in rate increases to implement a $1.00 per hour wage increase for direct support and other frontline personnel as well as to support changes to regional wage adjusters.
- **Specialized Mental Health Rehabilitation Facilities (SMHRFs).** $9.73 million was invested in add-on payments for SMHRFs to support quality of life and quality of care. The rate increase varied based on room occupancy.
- **Supportive Living Program (SLP).** SLP per diem rates were updated to be at least 54.75% of the average nursing facility per diem, based on geographic area, resulting in an annual increase of $4 million.
- **Substance Use Disorder Providers** received an annual 2% rate increase, resulting in an estimated $3.4 million being invested in services.
- **Dental and Sedation Services Providers.** Sedation evaluation, deep sedation, and IV sedation for dental services received a 33% rate increase, resulting in an annual reimbursement increase of $3.6 million.
- **Psychiatric Add-On Rates.** $11 million was invested in increasing add-on rates paid to board-certified psychiatrists and psychiatric/mental health advanced practice nurses for certain psychiatric services.

- **Optometrists and Optical Providers.** Refraction and spectacle-fitting services received a 35% rate increase, resulting in an estimated additional $5.34 million in reimbursement to providers.
- **Home Renal Dialysis within Skilled Nursing Facilities.** Certified home dialysis providers delivering dialysis services within a skilled nursing facility began receiving a per claim add-on payment of $95 per treatment, resulting in estimated annual increase for providers of $2.9 million.

Additional investments were also made to support rate increases for certain prosthetic and orthotic services, birthing centers, private duty nursing services, and services under the Adults with Developmental Disabilities 1915(c) Waiver.

Other Medicaid Service Expansions

- **Coverage of Peer Recovery Support.** Effective October 1, 2024, HFS expanded its behavioral health coverage to include peer recovery support services when delivered by a provider with a substance use treatment license. Peer recovery support services are delivered by persons with lived experience and provide non-clinical, strengths-based supports in support of a customer's treatment and recovery goals.
- **Streamlined Access to Behavioral Health Medications.** In September 2024, HFS removed the requirement for prior authorization of buprenorphine, reducing barriers to timely treatment for opioid use disorder. Additionally, prior authorization of medications for serious mental illness (SMI) was removed effective January 1, 2025, for stable customers experiencing a provider change, insurance change, or dosage change, while retaining necessary safety edits.
- **Expanded Access to Vaccinations**. In response to a measles outbreak in Illinois, HFS expanded coverage to allow early or extra doses of the measles, mumps, and rubella (MMR) vaccine for children aged 6 to 11 months who meet certain risk criteria. HFS also secured federal approval, effective January 1, 2025, to extend HPV vaccine coverage to customers ages 46+ who have been diagnosed with cervical dysplasia with a high risk of recurrence or progression.

- **Coverage of Remote Monitoring Services.** HFS opened reimbursement for remote ultrasounds and remote fetal nonstress tests when FDA-cleared, HIPAA-compliant digital technologies are used and in-person standards of care are met, enabling at-home monitoring for high-risk pregnancies. HFS also added coverage of self-measured blood pressure monitoring services, including customer education and training on device setup and use, allowing customers to monitor their blood pressure at different points in time outside the clinical setting. Both services were added effective January 1, 2025.
- **Improving Access to Oral Healthcare.** On July 1, 2024, HFS expanded reimbursement for dental anesthesia to include medical anesthesiologists, enabling hospitals and ambulatory surgical treatment centers to better support dental rehabilitation procedures. Effective January 1, 2025, HFS also updated its orthodontic scoring tool to expand automatic qualifiers and increase transparency in medical necessity determinations, supporting improved access to medically necessary orthodontic care.
- **Removing Barriers to Diabetes Management Services.** As of July 1, 2024, prior approvals for continuous glucose monitors are now issued for at least 12 months for any type of diabetes, reducing administrative churn and supporting continuity of care. Effective November 1, 2024, HFS also removed the upper age limit for diabetes prevention and management programs to include customers age 65+ who do not qualify for Medicare, closing an important access gap.
- **Genetic Testing Coverage Expansion.** Effective January 1, 2025, HFS opened additional codes to ensure comprehensive coverage of clinical genetic testing and evidence-based screenings for individuals with personal or family history of cancer, as recommended by a clinician under current guidelines.
- **Aligning Therapy (PT/OT/ST) Coverage with Clinical Practice**. Effective December 1, 2024, HFS updated its coverage policies for physical, occupational, and speech therapy (PT/OT/ST) to allow reimbursement for up to 2 hours of evaluation services per day and to permit same-day billing of evaluations and treatment. These changes remove unnecessary barriers to care and better align Medicaid policy with current clinical practice.
- **Long-Distance Transportation Expenses**. To improve access to medically necessary services for customers who require long-distance transportation, HFS expanded its transportation coverage to include reimbursement for meals, lodging, and costs incurred by non-employee attendants accompanying customers in long distance transportation. This expanded coverage took effect on March 1, 2025.

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Collaboration and Provider Supports

Children's Behavioral Health Transformation Initiative

During FY 2025, HFS continued its active role in the Children's Behavioral Health Transformation Initiative (CBHTI), established by Governor Pritzker in 2022 to improve access to coordinated, high-quality behavioral health services for children and adolescents with complex needs. HFS staff participate in weekly Interagency Crisis Staffing Team meetings, working directly with partner agencies to help families access appropriate services, including serving as the lead agency for any youth eligible for HFS-administered intensive behavioral health services or residential treatment. The Department also collaborated in the ongoing development and refinement of the statewide Blueprint for Transformation, which outlines strategies to centralize behavioral health access, expand service capacity, and strengthen early intervention to reduce the need for inpatient and residential care.

A key achievement of the CBHTI during FY 2025 was the development and rollout of the Behavioral Health Care and Ongoing Navigation (BEACON) portal, a new statewide tool designed to streamline how families identify available behavioral health services and connect with state-supported resources. Developed in partnership with Google and Illinois' 6 child-serving state agencies, BEACON establishes a single, more navigable entry point for families seeking assistance. The platform links families with Resource Coordinators, enables agency partners to accelerate access to residential and in-home supports, and allows parents to securely upload documents and receive guidance on school-based services. HFS helped support the roll-out of the BEACON portal, including establishing processes with Managed Care Organizations (MCOs) to prepare for referrals from BEACON and providing education and technical assistance to partnering organizations in preparation for increases in referrals to behavioral health services and programs because of the portal.

In addition, HFS advanced several program improvements informed by CBHTI feedback. The Department streamlined the Family Support Program (FSP) application process to better identify eligible youth and expedite access to intensive community-based mental health services aimed at improving family stability and clinical outcomes. HFS also collaborated with the CBHTI to develop a quality assurance plan that includes "secret shopper" reviews of Care Coordination and Support Organizations (CCSOs), helping ensure families consistently receive timely, accurate, and high-quality assistance.

Medicaid Technical Assistance Center (MTAC)

The Medicaid Technical Assistance Center (MTAC) is a partnership between HFS and the University of Illinois, Office of Medicaid Innovation (OMI) that provides training, technical assistance, and support to Illinois Medicaid providers. MTAC aims to assist and support community-based providers as they navigate enrollment and participation in the Illinois Medicaid Program, with the goal of increasing access to quality care for Medicaid customers across the State. Employing the experience and knowledge of 3 distinct MTAC teams (Outreach, Enrollment, and Assist), MTAC offers outreach, engagement, training, and one-on-one enrollment support for providers, regardless of their experience level with Illinois Medicaid. In FY 2025, MTAC supported providers through the following:

- **Certification of Behavioral Health Providers.** MTAC completed 134 initial and annual certification reviews for Behavioral Health Clinics (BHCs) and conducted 350 program reviews for specialized behavioral health services.
- **Portal Management.** MTAC provided support to HFS by facilitating the management of 2 online portals, the MCO Complaint portal and the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) portal, while also monitoring and assisting with questions received through OMI's IM+CANS support email for providers.
- **Technical Assistance.** Technical assistance specific to Doulas and Lactation Consultants was introduced, effectively providing guidance to providers on services, provider enrollment, and service codes and billing details related to the new Health Support Professional provider type. MTAC staff completed 250 technical assistance calls with community behavioral health providers, Adaptive Behavior Support (ABS) providers, and maternal health providers.
- **Training.** MTAC successfully launched training and support for new child and maternal health provider types, including doulas and lactation consultants. MTAC has trained 88 people for the Doula course and 70 for the Lactation Consultant course. MTAC staff also continues to provide in-person and live virtual training on demand for BHCs and ABS providers interested in joining the Illinois Medicaid program. And finally, MTAC hosted quarterly Learning Collaborative meetings for enrolled Behavioral Health Clinics, with focused learning on managed care contracting and introductions to MCO and fee-for-service billing.

Provider Assistance and Training Hub (PATH)

Launched in 2018, the Provider Assistance and Training Hub (PATH) is a partnership between HFS and the University of Illinois Urbana-Champaign School of Social Work (UIUC SSW) that provides no-cost clinical training, consultation, and support to community behavioral health providers across the state. PATH strengthens the behavioral health workforce through a broad range of training offerings, including crisis intervention skills, clinical interviewing and engagement techniques, care planning, safety practices, effective supervision, and strategies to address compassion fatigue and vicarious trauma. PATH also supports providers implementing Pathways to Success services and the Transformational Collaborative Outcomes Management (TCOM) framework, including training on the IM+CANS and the Illinois Medicaid Crisis Assessment Tool (IM-CAT).

In FY 2025, PATH expanded its training portfolio to respond to emerging provider needs and statewide priorities. New offerings included:

- Peer Support workforce training in partnership with the Illinois Department of Human Services Division of Behavioral Health and Recovery;
- Violence-prevention training developed with Texas A&M University and the Metropolitan Peace Academy;
- A statewide IM+CANS learning collaborative with enhanced coaching informed by feedback from the IM+CANS committee; and,
- New training on human trafficking awareness and response.

These additions further strengthened the capacity of Illinois' behavioral health providers to deliver high-quality, trauma-informed care. Through these continued efforts, PATH remained a critical resource in FY 2025 for providers seeking to enhance clinical skills, implement

PATH
PROVIDER ASSISTANCE AND TRAINING HUB

FY 2025 PATH: At-A Glance

Total Training Completions

- **13,478 total completions**
  - 5,841 facilitator-led webinar completions
  - 7,637 self-paced completions

Training Delivery

- **554** facilitator-led webinars delivered
- **9** new/updated trainings launched
- **9** CEU courses developed

CCSO Coaching & Quality Efforts

- **92 coaching sessions**
- **888 attendees** at statewide monthly Technical Assistance calls
- **109** participants in regional Learning Collaboratives
- Ongoing fidelity monitoring via document reviews and WrapStat WFI-EZ cycles across CCSOs

evidence-based practices, and better support the behavioral health needs of children, youth, and families across Illinois.

Illinois Medicaid-Certified Doula Program

During FY 2025, HFS continued to strengthen the Illinois Medicaid-Certified Doula Program in partnership with Southern Illinois University (SIU) to support provider growth ahead of Medicaid reimbursement for doula services. The SIU School of Medicine's Office of Certification Strategies managed application reviews, reference verification, and issuance of certificates for doulas meeting requirements related to prenatal, labor and delivery, and postpartum experience.

Developed collaboratively with community doulas, the certification framework recognizes both formal doula training programs and the substantial experience of long-serving practitioners. The program offers two pathways—Training Program and Legacy—through which eligible doulas can obtain state certification. This certification verifies a doula's training and experience and is the first step required to enroll as an Illinois Medicaid provider through the IMPACT provider enrollment system. While the program does not provide doula training itself, it establishes a comprehensive, standardized process that acknowledges the diversity of doula preparation across Illinois and the nation.

During FY 2025, 107 doulas were certified through the Illinois Medicaid-Certified Doula Program, helping build a more diverse and community-connected perinatal workforce prepared to serve Medicaid members across the state.

School-Based Health Services Program

Administered by HFS in partnership with local education agencies (LEAs), the School-Based Health Services (SBHS) program allows school districts to receive Medicaid reimbursement for a portion of the costs of providing direct medical and administrative services to Medicaid-enrolled students. Covered direct services include preventive care, nursing, mental health, physical and occupational therapy, speech-language services, and school health aide support, along with other benefits available under the Medicaid program. HFS' contracted partner, Public Consulting Group (PCG), continues to provide operational and technical support, including ongoing training and resources for LEAs.

880+ LEAs participate in the SBHS program. In FY 2025, the program served approximately 220,00 Medicaid enrolled students.

In April 2023, Illinois received federal approval to expand the SBHS program to cover services for all Medicaid-enrolled students. Previously, reimbursement was limited to students with Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs), restricting federal matching dollars to a far narrower group. The expanded policy now allows schools to draw down federal funds for a wider set of students who receive medically necessary services during the school day, improving access to care and strengthening school-based health supports.

The federal approval also modernized the LEA reimbursement methodology by shifting the program to an annual cost-settlement process based on the actual cost of delivering services. In June 2025, HFS finalized cost settlement for its second year operating under this updated approach, resulting in nearly **$315.3 million** in total reimbursement to LEAs, including **$121.9 million** attributable solely to the transition to cost settlement and **$23.4 million** tied to services delivered to the newly eligible student population. These results underscore the significant financial impact of the SBHS expansion and demonstrate how recent policy changes have strengthened school-based services and increased district capacity to support student health.

Provider Revalidation

In August 2024, HFS initiated a comprehensive effort to support Medicaid providers through the federally required revalidation process. In accordance with 42 CFR 455.414, all actively enrolled providers must renew their Medicaid provider agreements at least every 5 years. This requirement had been temporarily suspended during the federal COVID-19 public health emergency. Following the reinstatement of the federal mandate, HFS launched the first full revalidation cycle to ensure all providers maintain compliant enrollment status.

Revalidation is conducted in monthly cycles based on each provider's original enrollment date, and cycles will continue through February 2026. Upon completion of this initial full revalidation cycle, HFS will resume a standard revalidation cadence, ensuring all providers remain compliant

with the 5-year renewal requirement. To prevent gaps in participation, HFS issues revalidation notices to each provider 90 days and 30 days in advance of their revalidation cycle end date. Providers who do not complete revalidation before their cycle end date are disenrolled, resulting in a break in enrollment that interrupts payment and cannot be retroactively reinstated with federal match under federal regulations. This makes timely provider response essential to maintaining continuity of services for Medicaid customers and continuity of payment for Medicaid providers.

To promote provider awareness and enhance provider support throughout the process, HFS implemented an extensive outreach and engagement strategy during FY 2025. Through the Department's "Stay Connected" campaign, HFS communicated directly with providers and partnered with professional associations and other stakeholder organizations to broaden its reach. During fall 2024, HFS issued 4 provider notices to increase provider awareness of revalidation efforts, expectations, and timelines. Virtual town hall meetings held in fall 2024 and monthly throughout 2025 provided detailed guidance on navigating the revalidation process within the IMPACT provider enrollment system and introduced staff who support providers through the process.

By June 2025, HFS reached the midpoint of its statewide revalidation campaign and saw strong progress. Among actively enrolled providers, the completion rate reached 85%. In total, 56,253 revalidations were submitted, reflecting a 65% completion rate across all providers.

Providers who were disenrolled during the process continued to submit revalidations to restore their enrollment. HFS will maintain consistent communication and continue working with provider organizations to ensure compliance and to protect Medicaid customers' access to uninterrupted, high-quality care.

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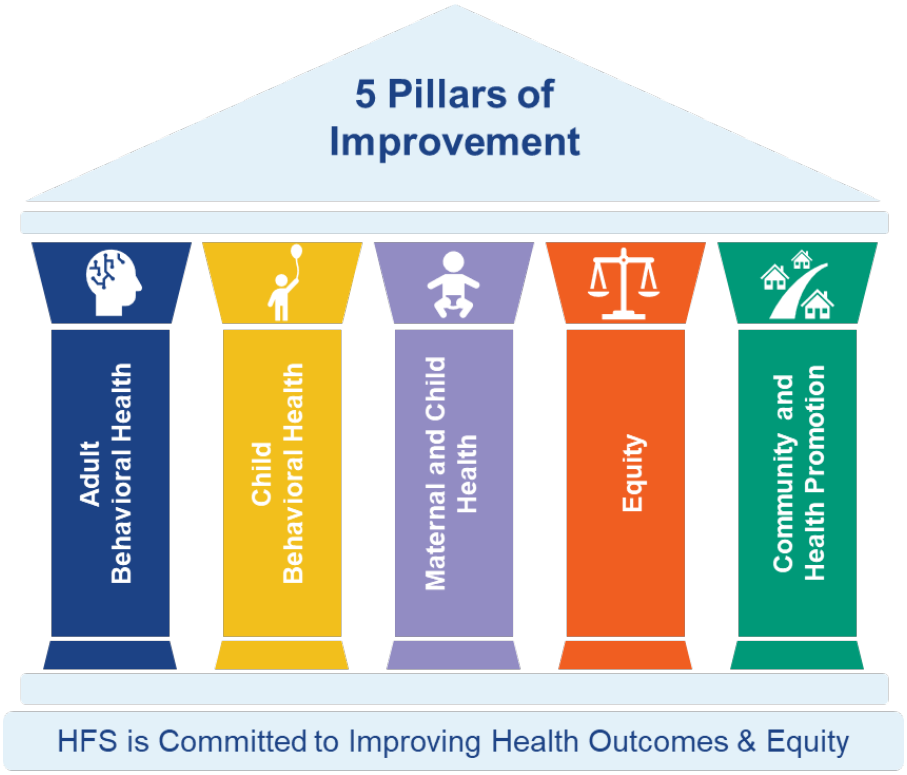
Quality Management

Comprehensive Medical Programs Quality Strategy

In FY 2024, HFS published the 2024-2027 Comprehensive Medical Programs Quality Strategy (Quality Strategy). Developed in accordance with federal regulations (42 CFR 438.340), the Quality Strategy is designed to foster the delivery of the highest-quality, most cost-effective services possible by establishing a framework for ongoing assessment and the identification of potential opportunities for healthcare coordination and improvement. It puts a strong focus on using data-driven decision making to address health disparities, improve population health, transition to value-based payment models, and promote community-based care.

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



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

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

Monitoring Managed Care Quality

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

External Quality Review

HFS contracts an external quality review organization (EQRO) to perform independent assessment of the quality, timeliness, and accessibility of the healthcare services provided by MCOs. The EQRO conducts external quality reviews to ensure that Medicaid customers receive appropriate and effective care. The key functions of the EQRO in Illinois include assessing MCO compliance with federal regulations and contractual requirements, validating performance measures, validating encounter data, reviewing provider network adequacy, conducting quality studies, and providing technical assistance. The EQRO prepares an annual, independent technical report that provides a description of how the data from all compliance activities were collected and analyzed, and conclusions drawn as to the quality and timeliness of, and access to the care furnished by MCOs. The EQRO annual report can be found on the HFS reports webpage.

2024-2025 External Quality Review Technical Report Findings

The 2024-2025 Illinois EQRO technical report (covering March 2024-February 2025) found that managed care plans perform strongly in several key areas of quality, access, and timeliness. Notable improvements were observed in behavioral health follow-up, maternal and child health, and chronic disease management. Statewide rates improved for follow-up after hospitalization and emergency department visits for mental illness, and well-child visits increased across both early childhood and adolescent populations. Maternal health measures also strengthened, with postpartum care rates rising approximately 5% and exceeding national benchmarks. Additionally, diabetes care continued trending upward, with improvements in blood pressure control, eye exams, and A1c measures.

At the same time, persistent gaps exist that require focused intervention. Substance use disorder (SUD) treatment access and engagement declined across multiple sub-measures, and preventive screening rates for women—such as cervical, chlamydia, and breast cancer screenings—remained below the 50th percentile statewide. Childhood and adolescent immunizations continued to underperform, and both adult and child CAHPS member experience scores revealed ongoing concerns about access to needed care, scheduling, and customer service. A 2024 provider access and availability study published in FY 2025 further underscored challenges, showing widespread inaccuracies in provider directories and limited appointment availability for behavioral health and prenatal care. In 2026, the Department intends to conduct a

review of certain types of service provider directories, including behavioral health and prenatal care, to assess and monitor accuracy.

Despite these challenges, health plans achieved strong results in compliance and network adequacy, with all plans ultimately scoring 100% in their 2024 compliance reviews and meeting the vast majority of time and distance standards statewide. Moving forward, targeted interventions—such as improving provider data accuracy, strengthening SUD care coordination, addressing social determinants of health affecting maternal and child outcomes, and expanding telehealth and outreach strategies—will be essential to advancing the State's Quality Strategy goals and ensuring more equitable, timely, and person-centered care for Medicaid members.

Quality Assessment and Performance Improvement (QAPI) program

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

The majority of the health plans demonstrated oversight and quality improvement process with focus centered on the health plan's strategic initiatives and HFS focus areas such as maternity and infant care, and which included behavioral health, ensuring enrollee's access to providers, and medication adherence.

Quality Metrics and Performance Targets

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

Pay for Performance (P4P) and Reporting (P4R)

The P4P and P4R programs are designed to improve quality by incentivizing spending on care that will increase quality of life outcomes. Under these initiatives, HFS selects a series of P4P and P4R measures, aligned with the 5 pillars of improvement, and sets performance targets for each. MCOs then have a percentage of their capitation rate withheld, which they can earn back by meeting or exceeding the established performance measure benchmarks. For the measurement year (MY) 2025 P4P and P4R program, MCOs were eligible to earn back unearned funds based on performance and improvement on the P4P measures in the Maternal and Child Health pillar. To be eligible to earn back unearned funds, MCOs were required to complete the Maternal Child Health (MCH) quality and equity improvement project evaluation report.

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

Consumer Report Cards

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

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

Each MCO is assigned up to five stars to indicate how it performs relative to other MCOs on each measure. The information used to create the Report Card is collected from the MCOs and their members and is reviewed for accuracy by HFS' contracted external quality review organization (EQRO) annually. For Report Card measures that were less than 3 stars, the Department required MCOs provide details for their plans and interventions that would improve those lower scoring ratings.

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Service Delivery Systems

Medicaid Service Delivery Systems

The HFS Medical Assistance Programs delivers healthcare to customers through two primary service delivery systems: fee-for-service (FFS) and managed care. Under the FFS system, HFS pays healthcare providers directly for each service provided to Medicaid customers. Under the managed care program, HFS contracts with Managed Care Organizations (MCOs), also commonly referred to as Health Plans, to operate the Medicaid benefit for eligible customers. This section of the report provides an overview of core programs, services, and initiatives within both FFS and managed care.

Illinois' Managed Care Program

In FY 2025, Illinois' statewide, integrated managed care program provided quality healthcare services and enhanced care coordination to upwards of 80% of all Medicaid customers. The managed care program aligns with HFS' mission and goals by advancing health equity, addressing social determinants of health, and promoting quality outcomes.

Key Components of Managed Care:

- **Care Coordination:** Care coordinators are assigned to help members, especially those with chronic conditions, identify care needs and navigate the healthcare system to meet those needs. To identify members with care coordination needs, the health plans assess risk for their enrolled population using predictive modeling and the completion of a health risk screening for all new enrollees.
- **Covered Benefits:** MCOs must offer their members the same comprehensive set of services available to the FFS population, unless specifically excluded. All MCOs offer extra benefits to their members, above and beyond what is available under the FFS system. A chart comparing these extra benefits offered can be found on the Illinois Client Enrollment Services website.
- **Capitated Payments:** MCOs are paid a fixed monthly payment (known as capitation) for each enrolled member, regardless of how many services the member uses. The MCO in turn is responsible for coordinating care and for directly reimbursing their network of providers who deliver care to their members. More information on managed care reimbursement is included later in this section.
- **Provider Networks**: Each MCO is required to have a robust, accessible network of healthcare providers from which their members receive care. These networks must consider factors such as provider types, specialist needs, geographic distribution, appointment wait times, and cultural and linguistic competency. Regular monitoring of MCO network adequacy is performed by the state's external quality review organization (EQRO).

- **Quality Monitoring**: HFS is required to implement quality and performance improvement within managed care in line with its Comprehensive Medical Programs Quality Strategy. Key elements of MCO quality monitoring include reporting on quality measures and performance outcomes, conducting targeted performance improvement projects, the publishing of a health plan report card, compliance monitoring in line with federal regulations.

Illinois Managed Care Programs

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

HealthChoice Illinois (HCI)

HFS contracts with 5 HCI health plans who serve:

- Families and children;
- ACA Adults;
- Seniors and adults with disabilities who are not eligible for Medicare;
- Dual Medicare-Medicaid eligible adults (dual eligibles) receiving certain LTSS, referred to as the MLTSS population;
- Special needs children, Former Youth in Care, and Youth in Care; and,
- Adults and senior immigrants.

In FY 2025, HFS advanced its preparations for the re-procurement of the HealthChoice Illinois (HCI) program, including hosting a series of in-person and virtual HealthChoice Listening Sessions to gather feedback from customers and stakeholders on their managed care experiences. The re-procurement of the HCI program will serve as a major agency priority in FY 2026.

HealthChoice Illinois YouthCare (YouthCare)

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

Throughout 2025, YouthCare prioritized strengthening care quality, access, and coordination across behavioral health, inpatient services, and residential care programs. Key initiatives

included expanded care management, enhanced member supports, whole-person community investments and targeted youth-focused programs.

Medicare Medicaid Alignment Initiative (MMAI)

The MMAI 3-way partnership between HFS, CMS, and 5 MCOs delivers care to customers who are eligible for both Medicare and Medicaid services. These dually eligible customers enrolled in MMAI receive the full range of services covered under the Medicare and Medicaid programs, including LTSS services. Providers bill one MCO, regardless of whether the service is covered under Medicare, Medicaid, or both. Enrollment in MMAI is voluntary; customers can opt in or out of the program at any time.

Transition from MMAI to Fully Integrated Dual Eligible Special Needs Plans

In 2022, CMS announced it was ending the Financial Alignment Initiative demonstration, which included Illinois' MMAI program, and issued a final rule focused on strengthening integration in dual eligible special needs plans (D-SNPs). Illinois elected to preserve its Medicare and Medicaid integrated care model by transitioning MMAI to a fully integrated dual eligible special needs plan (FIDE-SNP) model effective January 1, 2026. Like MMAI, FIDE-SNPs combine Medicare and Medicaid benefits under a single managed care plan, offering enhanced coordination and comprehensive coverage services—including long-term services and supports, behavioral health, transportation, home health, and an integrated drug formulary—to create a more seamless experience for dual-eligible customers.

Throughout FY 2025, HFS undertook substantial preparation to support this transition. The agency released a competitive Request for Proposals (RFP) in September 2024 and, in March 2025, awarded 4 statewide FIDE-SNP contracts to Aetna, Humana, Meridian, and Molina. Implementation activities began immediately, including preparing to conduct Readiness Reviews in early FY 2026. As these efforts advance, HFS will ensure MMAI members are fully informed of their options, whether being automatically transitioned into an affiliated FIDE-SNP, selecting a different plan during the Medicare Annual Enrollment Period, or choosing other coverage. HFS will work closely with the Senior Health Insurance Program (SHIP), the Home Care Ombudsman Program, AgeOptions, and advocacy partners to support customers and stakeholders throughout the transition.

MCO Program Enrollment Numbers

HealthChoice Illinois (HCI)

Enrollees: Children and their parents, ACA adults, seniors and persons with disabilities, special needs children, Youth in Care, former Youth in Care, adults and senior immigrants, and dual eligible adults aged 21+ who receive LTSS and have opted out of MMAI.

Geographic Service Area: Statewide

Mandatory Enrollment: Yes

Health Plan	June 2025 Enrollment
Aetna Better Health of Illinois	339,108
Blue Cross Community Health Plans	716,643
CountyCare Health Plan (Cook County only)	413,211
Meridian Health	658,942
Molina Healthcare	284,518
YouthCare	32,205
Total HCI Enrollment	**2,444,627**

Medicare-Medicaid Alignment Initiative (MMAI)

Enrollees: Dual eligible adults aged 21+ who are eligible for both Medicare and Medicaid services and who have not opted out of MMAI.

Geographic Service Area: Statewide

Mandatory Enrollment: No

Health Plan	June 2025 Enrollment
Aetna Better Health Inc.	13,893
Blue Cross and Blue Shield of Illinois	18,786
Humana Health Plan	13,707
Meridian Complete Health Plan Inc.	14,201
Molina Healthcare of Illinois	14,207
Total MMAI Enrollment	**74,794**

Total Managed Care Programs Participation	Health Plan	June 2025 Enrollment
HCI, MMAI	Aetna Better Health Inc.	353,001
HCI, MMAI	Blue Cross and Blue Shield of Illinois	735,429
HCI	CountyCare Health Plan	413,211
MMAI	Humana Health Plan	13,707
HCI, MMAI	Meridian Complete Health Plan Inc.*	705,348
HCI, MMAI	Molina Healthcare of Illinois	298,725
	Total Managed Care Enrollment	**2,519,421**

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

Managed Care Program Reimbursement

HCI Capitation Rates

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

MMAI Capitation Rates

Both CMS and HFS contribute to the global MMAI capitation payments. MMAI MCOs receive 3 monthly payments for each enrollee: one from CMS reflecting coverage of Medicare Parts A/B services; one from CMS reflecting coverage of Medicare Part D services; and one from HFS reflecting coverage of Medicaid services. The Medicare Parts A/B rate component and the Medicare Part D payment are risk adjusted using the prevailing CMS risk adjustment models, while the Medicaid rate component is adjusted based on an enrollee's age, geographic service area, and care setting (nursing facility, HCBS waiver, or community). It includes an LTSS

blended rate based on the nursing facility and HCBS waiver enrollment mix in each MCO at the beginning of the calendar year. The nursing facility portion of the blended LTSS rate is risk adjusted.

Directed and Pass-through Payments

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

Pay for Performance (P4P) and Reporting (P4R)

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

Medical Loss Ratio (MLR)

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

Long Term Care Program

HFS is responsible for the Medicaid Long Term Care (LTC) program, which served 75,500 eligible residents across more than 800 institutional facilities in FY 2025. There are four basic types of institutional settings in the LTC program: Nursing Facilities (NF), Specialized Mental Health Rehabilitation Facilities (SMHRFs), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and Medically Complex for the Developmentally Disabled (MC/DD).

Licensed and Medicaid Certified LTC Beds (FY 2025 Actual)

Level of Care	Medicaid Certified Beds[1]	Licensed Beds[2]
Skilled Care	68,972	76,774
Specialized Mental Health Rehabilitation Facilities (SMHRFs)	N/A	3,408
Intermediate Care (ICF)	8,254	7,680
Intermediate Care for Individuals with Intellectual Disabilities (ICF/IID)	3,830	3,830
Skilled Care for Individuals with Intellectual Disabilities	1,162	1,162
Total	**82,218**	**92,854**

1 Reflects beds that participate in the medical assistance program and are available to Medicaid residents.
2 Reflects beds licensed to operate under the Nursing Home Care Act, the MC/DD Act, the ID/DD Community Care Act, and provisional licensure through the Specialized Mental Health Rehabilitation Act of 2013.
Note: Sheltered Care beds are not certified for Medicaid. Table prepared by Bureau of Long Term Care.

Certification/Decertification of LTC Facilities

During FY 2025, 10 NFs closed. Of those, 8 closed due to financial reasons, 1 closed due to a lease not being renewed, and 1 was involuntarily terminated. No new NFs enrolled in the Medical Assistance Program during this same period. HFS works collaboratively with MCOs, DPH, and DHS to ensure Medicaid customers are appropriately transitioned to other nursing facilities when closures occur.

LTC Provider Assessment

The LTC provider assessment program makes use of a provision in federal law that allows states to claim federal financial participation (FFP) on payments for NF and ICF/IID services that are funded from the receipts of taxes paid by those facilities. These funds have helped HFS provide critical institutional services to some of the neediest and most frail Illinoisans. On July 1, 2022, the LTC assessment program was restructured to terminate a $1.50 assessment on licensed beds days and to revise the assessment on non-Medicare occupied bed days from a uniform tax of $6.07 to a varied tax based on the provider's volume of Medicaid days. This change nearly doubled the assessment collections as well as the federal revenues in its first year and continued to increase in FY 2025.

Funds Generated by the LTC Provider Assessment

Fiscal Year	Nursing Facilities	ICF/IIDs
2022	$160.6 M	$20.7 M
2023	$302.3 M	$20.8 M
2024	$327.9 M	$21.5 M
2025	$336.6 M	$23.4 M

Nursing Facility Reimbursement

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

Under certain circumstances, recently enrolled NFs are required to file an initial cost report that may result in capital and/or support component revisions. Initial cost reports resulted in rate revisions for one (1) NF. Additionally, capital exceptions resulted in rate changes for 63 NFs in FY2024.

Nursing Home Rate Reform

In FY 2025, HFS continued implementing comprehensive Medicaid payment reforms for nursing facilities designed to improve quality of care and strengthen the long term care workforce. Building on legislation enacted in 2022, the updated reimbursement model links Medicaid payments more directly to resident acuity, staffing levels, and quality performance, while increasing transparency in how funding supports direct resident care. The reform package included the following key changes:

- **New nursing home assessment.** The nursing home bed tax was streamlined from a two-pronged tax comprised of $6.07 per occupied bed day plus $1.50 per licensed bed to a single tax with a variable rate based on Medicaid resident days. This change resulted in an increase of the state's taxing authority to nearly 6% of total revenue, providing additional revenue to help fund the reform's staffing and quality initiatives.
- **Adoption of a Patient-Driven Payment Model (PDPM)**. Illinois transitioned from the Resource Utilization Group (RUG) methodology to the PDPM, a case-mix methodology designed to reflect the clinical care needs of residents more accurately. This model

mitigates financial incentives related to the volume of services provided, focusing instead on the individual needs of each resident.

- **Linking payment to staffing levels**. A new add-on payment is now included in the rate calculation based on the facility's STRIVE staffing level. The add-on rewards facilities with sufficient and sustained levels of staffing, while still providing support and incentive for lower staffed facilities to invest in new staff.
- **Pay scale for Certified Nursing Assistants (CNAs)**. Although CNAs play a pivotal role in the day-to-day care of nursing facility residents, often serving as the primary caregivers and the frontline of patient interaction, their compensation has not historically reflected the importance and demands of their work. The reform introduced a unique payment program that reimburses providers for the Medicaid portion of retention and promotion-based wage increments for CNAs, most rewarding long-serving CNAs.
- **Rewarding Quality and Performance.** Increased staffing is expected to improve quality, but to further incentivize nursing facilities providing safe and high-quality care, Illinois established a Quality Incentive Payment program that annually distributes $70 million based upon federally published Medicare Star ratings. Providers must receive at least a 2-Star rating to receive funding. As provider long stay Star ratings increase, they receive a higher proportion of the pooled funding.

1915(c) Home and Community-Based Services Waivers

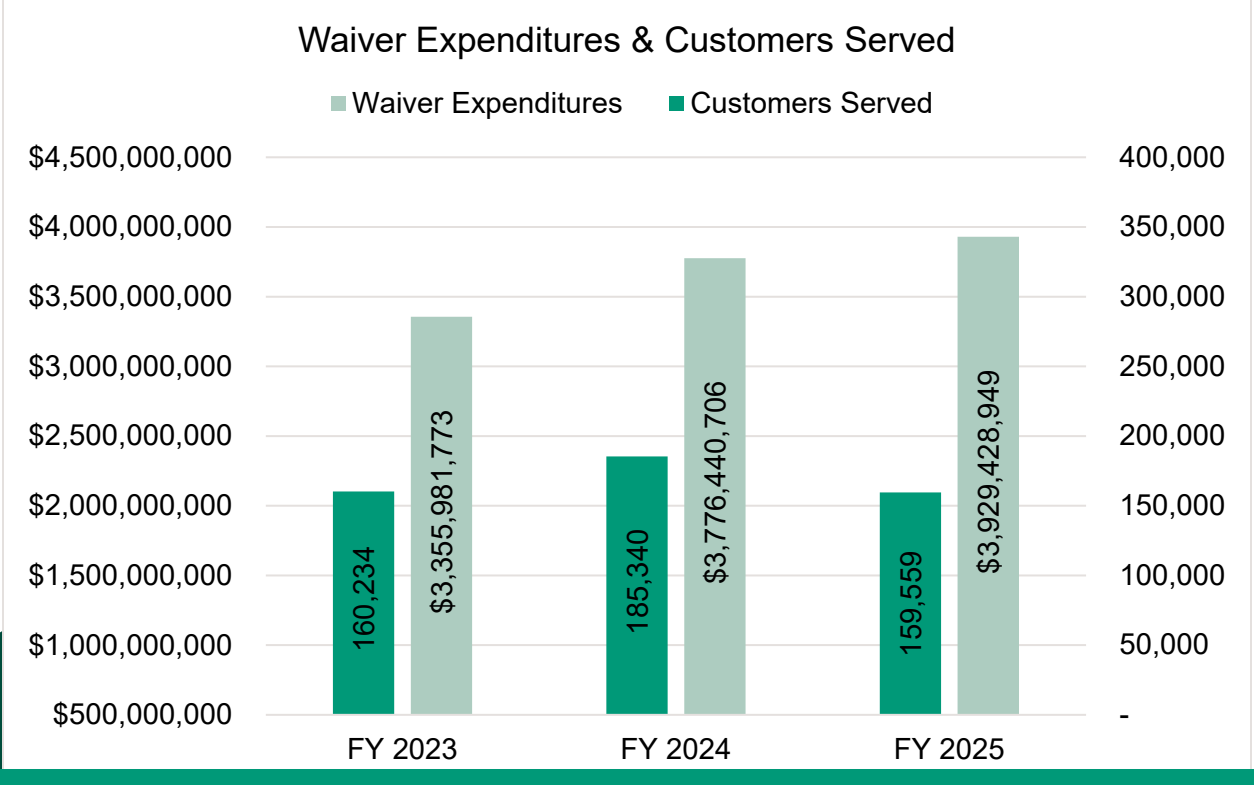
A Medicaid 1915(c)home and community-based services (HCBS) waiver allows states to provide long term services and supports in community settings rather than institutional facilities, such as nursing homes. These waivers promote independence, community integration, and cost savings by reducing reliance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

Illinois' 9 1915(c) HCBS waivers served a total of 159,559 customers in FY 2025.

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

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

Find detailed information on each waiver on the HFS HCBS webpage.



Supportive Living Program Enhancements

In FY 2025, the Supportive Living Program (SLP) continued its strategic expansion to meet growing demand for community-based long-term services and supports. Following a Request for Applications (RFA), 9 new SLP providers were approved and added to the program, resulting in 392 additional apartments and increasing available resident occupancy by 509 individuals. This expansion enhances geographic access, increases dementia-capable capacity, and strengthens the program's ability to support residents in the least restrictive setting.

FY 2025 also included several important policy and rate updates designed to improve service quality and financial stability for SLP providers. Effective January 1, 2025, Medicaid rates for supportive living services increased to 54.75% of the average total nursing facility per diem for each geographic area, and the personal needs allowance (PNA) for Medicaid-eligible SLP residents increased from $90 to $120. Additionally, SLP providers may now hire Certified Medication Aides, who will be regulated by IDPH similarly to CNAs. A legislatively required rate add-on for the provision of two meals per day ($6.15/day)—first established on January 1, 2023—was reaffirmed in FY25 and becomes permanently effective July 1, 2025.

In March 2025, HFS implemented the new SLP Quality Metrics Process (QMP), which introduced a $2.75 per-day quality add-on tied to provider performance on staffing hours per resident day, unplanned hospitalizations, and emergency department visits. Benchmark data is collected and analyzed quarterly, with prospective payment adjustments applied based on validated performance. Collectively, these FY25 updates strengthen program quality, accountability, and the overall sustainability of Illinois' supportive living model.

Electronic Visit Verification

In FY 2025, HFS continued implementing the statewide Electronic Visit Verification (EVV) system to support oversight of Medicaid-funded HCBS. EVV is a federally required system under the 21st Century Cures Act that verifies key details of home healthcare visits, including the type of service provided, the individual receiving care, the caregiver delivering services, and the time and location of each visit. The system helps improve program integrity, reduce billing errors, and strengthen oversight of personal care services and home health care. Providers may use the state-sponsored data platform operated by HHAeXchange or another compatible EVV vendor, but all visit data must ultimately be transmitted to the statewide platform for compliance monitoring and program oversight.

Illinois has taken a phased approach to implementing EVV. In 2023, the state launched EVV requirements for all home health care services and for personal care services under the 1915(c) HCBS waivers administered by DHS-DDD. All providers currently required to use EVV had to achieve a minimum overall EVV compliance rate of 50% by May 1, 2025. HFS and its partners

continue to collaborate to plan for the implementation of EVV for additional 1915(c) waiver programs.

Throughout FY 2025, HFS and its partners continued to collaborate and plan for the implementation of EVV across additional 1915(c) waiver programs, while also supporting implementing providers in strengthening their compliance through regular outreach and technical assistance, including statewide town hall webinars and training resources.

Money Follows the Person

The Money Follows the Person (MFP) Demonstration is a federal grant program that helps states shift long-term care systems toward community-based services by supporting Medicaid customers transitioning from institutional settings to HCBS. Originally authorized under the 2005 Deficit Reduction Act, the program has been extended multiple times to continue funding.

In fall 2022, Illinois received a $5 million MFP Planning Phase grant to assess gaps in current HCBS services, strengthen recruitment and retention of direct care workers and other home-based providers, and develop an Operational Protocol for the Implementation Phase. HFS' MFP funding has been renewed through September 2026.

In support of the MFP Demonstration and deliverables, HFS hired a dedicated Project Manager and a Data/Quality Analyst Manager. In FY 2025, HFS partnered with the University of Illinois Chicago to complete a statewide HCBS gap analysis. Planning Phase activities continued in collaboration with DHS, IDoA, the Illinois Housing Development Authority (IHDA), advocates, potential participants, and other stakeholders.

Hospital Provider Reimbursement

Hospitals are reimbursed in several ways, including:

- Inpatient Claims
- Outpatient Claims
- Disproportionate Share Hospital Payments
- Hospital Assessment-Funded Supplemental Payments
- Payments from Managed Care Organizations.

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

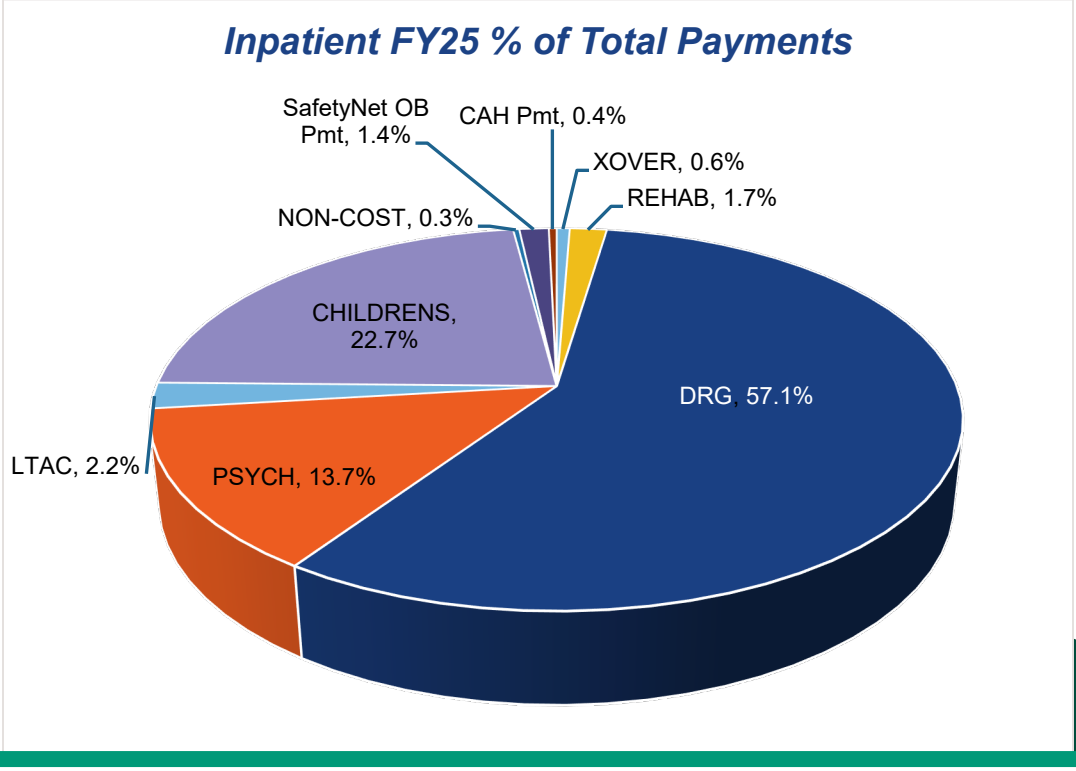
Inpatient Hospital Services - General Revenue Fund (GRF)

Inpatient hospital claims consist of acuity-based groupings, called All Patient Refined Diagnosis Related Groups (APR-DRG) with several specialized claims-based add-ons, including disproportionate share, safety-net, psychiatric, Medicaid Percentage Adjustment and Medicaid High Volume Adjustment. Some types of claims are excluded from the APR-DRG and continue to be paid on a per diem basis, including psychiatric and rehabilitation hospital claims and services provided by long-term acute care (LTAC) hospitals and non-cost reporting hospitals.

Total FY 2025 hospital inpatient liability, including payments for both FFS and MCO claims totaled $3.6 billion, up 5% from the $3.4 billion spent in FY 2024. Inpatient admissions saw a 2% decrease in FY 2025. A total of 251 cost-reporting hospitals participated in the Illinois Medicaid program in FY 2025.

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

As shown in the following graph, 57% of the $3.6 billion in FY 2025 hospital inpatient payments were made pursuant to the APR-DRG based system; this is down from 59% in FY 2024.

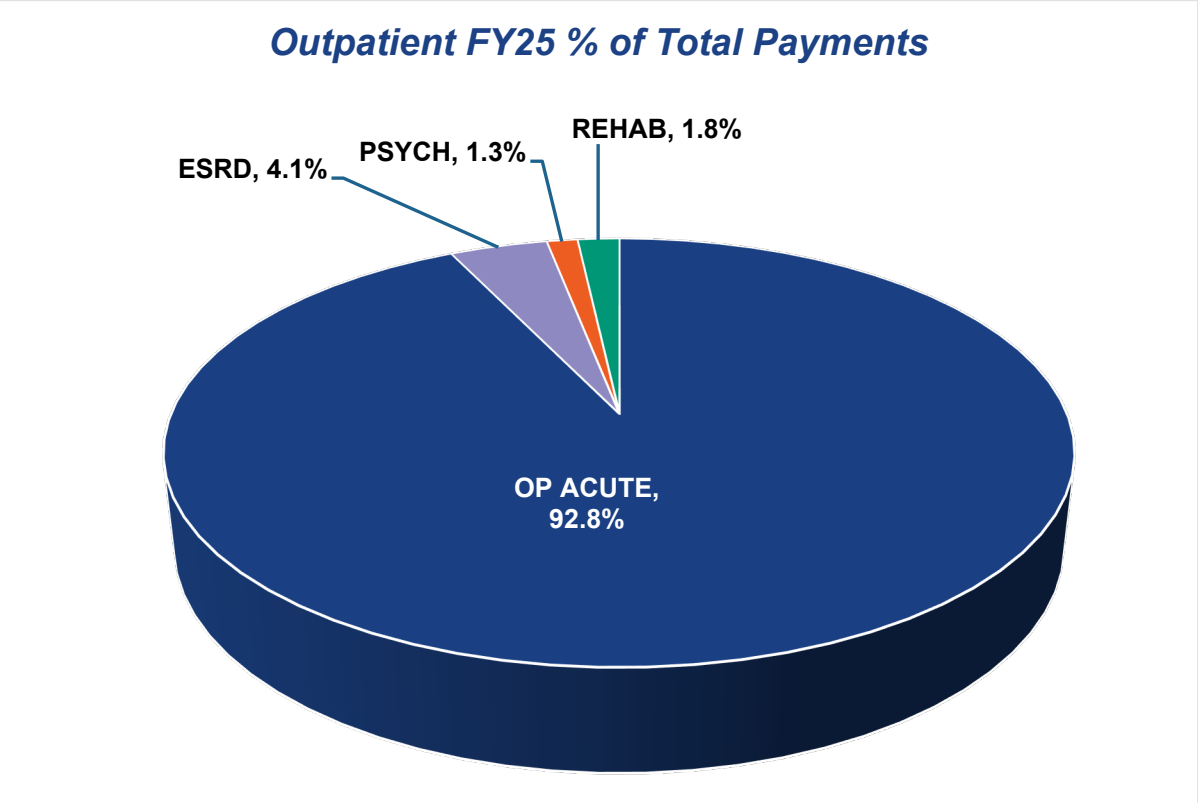


Ambulatory Care Services

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

Total spending on outpatient claims paid via the EAPG system increased 4% to $2.6 billion in FY 2025, compared to $2.5 billion in FY 2024. FY 2025 also saw a 5% decrease in the number of outpatient services provided, from 8.8 million services in FY 2024 to 8.3 million in FY 2025.

FY 2025 GRF Hospital Outpatient Spending - $2.5 billion



Disproportionate Share Hospitals (DSH)

Federal law requires hospitals that serve a disproportionate number of low-income patients with special needs be given an appropriate increase in their inpatient rate or payment amount. Additionally, states are federally mandated to provide the increased payment to any hospital whose Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate or whose low-income utilization rate exceeds 25%. In FY 2025, HFS expended $257.72 million of its federal Disproportionate Share Hospital (DSH) allotment, which equated to about $526.1 million in total spending including state matching funds.

The following numbers of hospitals qualified for DSH in rate year 2025:

- 72 private (non-governmental) hospitals, including 26 which received DSH payments because they were within the federal guidelines set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1993;
- 1 State-operated psychiatric hospital qualified for DSH because their low-income utilization rate exceeded 25%; and
- Government-owned hospitals (University of Illinois Hospital and Cook County Hospitals and Health Systems).

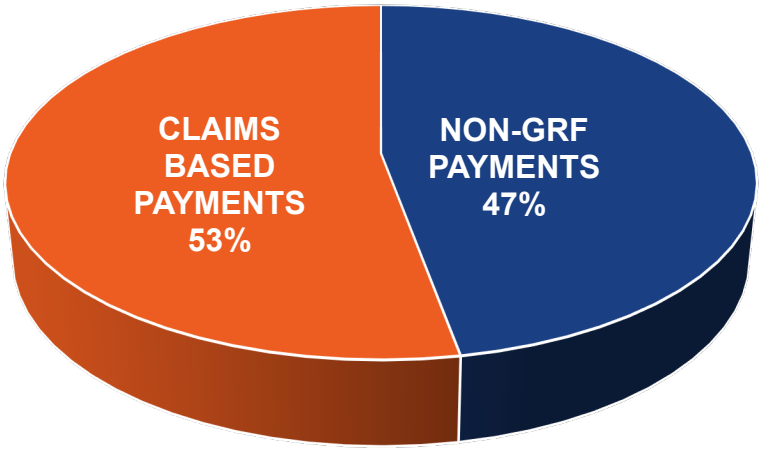
As federally required, HFS performs an annual OBRA calculation to ensure that spending to each hospital does not exceed the combined costs of services to the Medicaid and uninsured populations.

Non-GRF Funded Hospital Payments

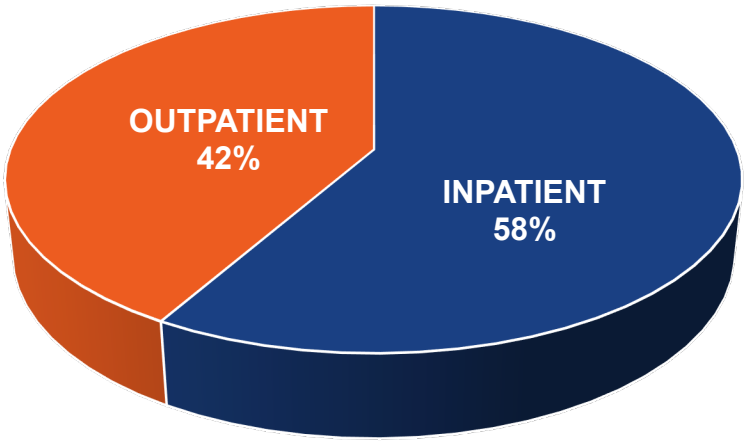
In accordance with Public Acts 95-0859, 97-0688, and 98-0104, HFS is authorized to make hospital access improvement payments to qualifying hospitals. Instead of the state's portion of the payments being funded through GRF, these payments utilize funding garnered through both an inpatient and outpatient assessment on Illinois hospitals. In calendar year 2025, HFS received federal approval to increase the hospital assessment and the corresponding payments to hospitals effective January 1, 2025. This allowed an additional $1.3 billion in payments to be made in the second half of FY 2025.

In total, $5.5 billion in payments were made to the hospitals in FY 2025 through supplemental payments paid directly to the hospitals (FFS) or through managed care plans (Managed Care Assessment Payments, MCAP).

Total FY 2025 Hospital Non-GRF Payments vs Claims Payments



Total FY 2025 Hospital Payments Inpatient vs Outpatient



Effective July 1, 2020, the hospital assessment program includes payment methodologies that can fluctuate each quarter of the year, resulting in the state's financial liability being higher or lower than the original amount of the hospital tax assessed to fund those payments. To fund this, the Department may adjust the tax on a semi-annual basis by subtracting the modeled payments from the actual payments during the previous assessment period and multiplying by .3853 to account for the state's estimated liability for the payments.

For the period of January 2024 through July 2024, the amount of actual payments over the modeled amount was $515.1 million. Therefore, the tax adjustment was an increase of $198,480,852. See calculations below:

Tax Increase Calculations for 07/01/2024

Actual Payments 01/01/2024– 06/30/2024	$2,088,772,543
Less Modeled Payments	$1,573,639,266
Payment in Excess	**$515,133,277**
	x .3853
Tax Increase	**$198,480,852**

Aggregate payment amounts for the period of July 1, 2024, through December 31, 2024, totaled $538.6 million more than modeled. To fund these payments, the tax adjustment implemented in January 2025 of $207,523,616 is detailed below:

Tax Increase Calculations for 01/01/2025

Actual Payments 07/01/2024– 12/31/2024	$2,112,241,956
Less Modeled Payments	$1,573,639,226
Payment in Excess	**$538,602,690**
	x .3853
Tax Increase	**$207,523,616**

8

Appendices

APPENDIX I – AGENCY CONTACT INFORMATION

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

Phone: 217-782-1200

Email: HFS.Webmaster@illinois.gov

Customer Hotline Numbers

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

Hotline	Phone Number
All Kids Hotline	1-866-255-5437 / 1-877-204-1012 (TTY)
All Kids Credit Card Payment Hotline	1-877-828-2375
Crisis Referral and Entry Service (CARES) *Behavioral Health Crisis Dispatch Hotline*	1-800-345-9049 / 773-523-4504 (TTY)
Eligibility Inquiry Hotline	1-855-828-4995
Illinois Client Enrollment Broker	1-877-912-8880 / 1-866-565-8576 (TTY)
Illinois Health Benefits Hotline	1-800-226-0768 / 1-866-214-8325 (TTY)

Healthcare Provider Hotline Numbers

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

APPENDIX II – HEALTH CARE PROGRAMS

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

1619A and 1619B

Description – Individuals who are employed. 1619(a) individuals have employment earnings low enough to receive some portion of a Supplemental Security Income (SSI) check. 1619(b) individuals have higher earnings and receive no SSI income benefits.
Presumptive Eligibility[1] – No **Benefit Type** – Comprehensive **Cost Sharing**[2] – No

Affordable Care Act (ACA) Adults

Description – Adults aged 19-64 without minor children in the home who do not receive Medicare and have income up to 138% of the federal poverty level (FPL). In 2025, this translates to $1,799 per month for an individual or $2,432 for a couple.
Presumptive Eligibility – Yes **Benefit Type** – Comprehensive **Cost Sharing** – No

Aid to Aged, Blind, and Disabled (AABD)

Description – Persons who are age 65 and older, who are blind or disabled, with monthly income up to 100% FPL (in 2025, $1,304 for a single person or $1,762 for a couple) and no more than $17,500 of non-exempt resources.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – No

All Kids Assist

Description – Children up to age 19 with family income at or below 318% FPL. In 2025, this translates to $8,519 per month for a family of 4.
Presumptive Eligibility – Yes **Benefit Type** – Comprehensive **Cost Sharing** – No

Department of Children and Family Services (DCFS) Youth

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

Emergency Medical for Non-Citizens

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

FamilyCare Assist

Description – Parents and caretaker relatives raising dependent minor children with an income at or below 138% FPL. In 2025, this translates to $3,697 per month for a family of 4.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – Yes

Family Planning

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

Former Foster Care

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

Health Benefits for Asylum Applicants and Torture Victims

Description – Individuals 19 years of age and older with pending applications for asylum with the U.S. Citizenship and Immigration Services or who receive services from a federally funded torture treatment center. Same income and resource standards as the AABD program.
Presumptive Eligibility – No **Benefit Type** – Comprehensive for limited time **Cost Sharing** – No

Health Benefits for Immigrant Adults (HBIA) (program sunset 07/01/2025)

Description – Illinois residents ages 42 through 64 whose immigration status does not meet the requirements for coverage under another eligibility group.
Presumptive Eligibility – No **Benefit Type** – Partial **Cost Sharing** – Yes

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

Description – Illinois residents aged 65 and over whose immigration status does not meet the requirements for coverage under another eligibility group. Eligibility criteria are otherwise similar to AABD.
Presumptive Eligibility – No **Benefit Type** – Partial **Cost Sharing** – Yes

Health Benefits for Persons with Breast or Cervical Cancer

Description – Individuals under age 65 without insurance that covers cancer treatment and whose breast or cervical cancer diagnosis has been confirmed by the Department of Public Health (DPH). There is no income limit or resource test.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – No

Health Benefits for Workers with Disabilities (HBWD)

Description – Employed persons, aged 16-64, with disabilities and earnings up to 350% FPL (in 2025, $4,564 per month for an individual, $6,168 per month for a couple) who buy into Medicaid by paying a small monthly premium. May have up to $25,000 in non-exempt resources.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – Yes

Moms and Babies

Description – Pregnant women and their babies up to age 1 with family income at or below 213% FPL. In 2025, this translates to $5,706 a month for a family of 4, inclusive of the unborn baby. Babies under 1 are eligible at any income level if Medicaid covered their mother at the time of birth.
Presumptive Eligibility – Yes **Benefit Type** – Comprehensive **Cost Sharing** – No

Medicare Savings Program (MSP)

Description – There are 3 programs for individuals eligible for Medicare Part A: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIB), and Qualified Individual (QI-1). Income limits vary per program; however, income is less than or equal to 135% FPL plus $25 (monthly SSI income disregard). Resource limits are $9,660 for a single person and $14,470 for a couple.
Presumptive Eligibility – No **Benefit Type** – Limited to coverage of Medicare cost sharing expenses

Cost Sharing – N/A

Veterans Care (new enrollment closed effective March 2016)

Description – Uninsured veterans aged 19-64 who were not dishonorably discharged from the military, served 180 days in the military after initial training, are income eligible, and who are not eligible for healthcare from the U.S. Department of Veterans Affairs or medical assistance under the Illinois Public Aid Code.
Presumptive Eligibility – No **Benefit Type** – Comprehensive **Cost Sharing** – Yes

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

State Chronic Renal Disease Program

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

State Hemophilia Program

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

State Sexual Assault Survivors Emergency Treatment Program

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

APPENDIX III – MANDATORY & OPTIONAL SERVICES

Federally Mandated Services in FY 2025

The following services are required to be provided in the Medicaid, CHIP, and certain All Kids programs: Certified pediatric and family nurse practitioner services

- Emergency service for non-citizens Emergency services
- EPSDT: Early and Periodic Screening, Diagnostic and Treatment Services for individuals under age 21
- Family planning services and supplies Federally qualified health center services Freestanding birth center services
- Home health services
- Inpatient hospital services
- Laboratory and X-ray services
- Medical/surgical services by dentist
- Medication Assisted Treatment (MAT)
- Nurse midwife services
- Nursing facility services (age 21 and over)
- Outpatient hospital services
- Physician medical and surgical services
- Routine patient costs of items and services for beneficiaries enrolled in qualifying clinical trials
- Rural health clinic services
- Tobacco cessation counseling for pregnant women
- Transportation to covered medical services

Optional Services Provided in FY 2025

The following services are covered by HFS in the Medicaid, CHIP, and certain All Kids programs but are not required to be covered under federal law: Acupuncture services, limited to procedures related to lower back pain and breech baby treatment

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

APPENDIX IV – EXPENDITURES AGAINST APPROPRIATIONS

HFS Medical Assistance Program

Expenditures Against Appropriations FY 2023 – 2025 (dollars in thousands)

	FY 2023 Expenditures	Percent	FY 2024 Expenditures	Percent	FY 2025 Expenditures	Percent
Total [1,2]	**$25,376,570.8**	**100.0%**	**$26,587,103.50**	**100.0%**	**$27,737,565.80**	**100.0%**
Hospitals	**1,131,598.0**	**4.5%**	**1,211,469.9**	**4.6%**	**1,252,390.7**	**4.5%**
Long Term Care [3]	**562,791.7**	**2.2%**	**640,324.9**	**2.4%**	**794,334.2**	**2.9%**
Practitioners	**282,924.0**	**1.1%**	**329,497.4**	**1.2%**	**327,010.5**	**1.2%**
Physicians	233,843.4	0.9%	275,075.9	1.0%	280,863.3	1.0%
Dentists	43,511.4	0.2%	49,272.0	0.2%	41,116.2	0.1%
Optometrists	3,942.2	0.0%	3,472.2	0.0%	3,576.1	0.0%
Podiatrists	1,614.3	0.0%	1,645.6	0.0%	1,423.8	0.0%
Chiropractors	12.7	0.0%	31.7	0.0%	31.1	0.0%
Drug	**1,096,917.5**	**4.3%**	**1,223,178.6**	**4.6%**	**1,181,278.0**	**4.3%**
Other Medical	**2,292,681.2**	**9.0%**	**2,347,293.9**	**8.8%**	**2,633,223.3**	**9.5%**
Laboratories	79,779.0	0.3%	41,132.7	0.2%	40,468.3	0.1%
Transportation	682,643.4	2.7%	651,987.0	2.5%	665,005.1	2.4%
SMIB/HIB/Expansion	779,280.9	3.1%	806,836.1	3.0%	875,343.7	3.2%
Home Health Care/DSCC	203,670.7	0.8%	216,644.4	0.8%	253,029.7	0.9%
Appliances	34,037.9	0.1%	28,716.5	0.1%	30,302.9	0.1%
Other Related [5]	294,746.1	1.2%	371,738.9	1.4%	503,476.3	1.8%
Community Health Centers	55,249.8	0.2%	61,526.8	0.2%	63,403.0	0.2%
Medically Complex Development (MCDD)	118,317.3	0.5%	118,485.5	0.4%	140,854.1	0.5%
Hospice Care	44,956.1	0.2%	50,226.0	0.2%	61,340.2	0.2%
MCOs	**20,009,658.4**	**78.9%**	**20,835,338.8**	**78.4%**	**21,549,329.1**	**77.7%**
Children's Health Rebate	**0.0**	**0.0%**	**0.0**	**0.0%**	**0.0**	**0.0%**

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

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

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

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

Table Prepared By: Division of Finance Data Source: Division of Finance, Comptroller Spending Report FY'25.

APPENDIX V – MEDICAL ASSISTANCE PROGRAM BOARDS AND COMMISSIONS

The HFS Boards and Commissions listed oversee and advise Illinois' elected officials, state agencies and organizations on a wide range of issues that affect the Medical Assistance Program. These boards and commissions also play a vital role in promoting efficient, effective, and honest government. More information, including members and meeting information, can be found on the HFS Boards and Commissions webpage.

- Advisory Council on Financing and Access to Sickle Cell Disease Treatment and Other High-Cost Drugs and Treatment *(sunset December 2024)*
- Beneficiary Advisory Council (BAC) *(new in 2026)*
- Breakthrough Therapies for Veteran Suicide Prevention Program Advisory Council
- Child Welfare Medicaid Managed Care Implementation Workgroup
- Dental Policy Review Committee
- Drug Utilization Review Board (DUR Board)
- Illinois Drugs and Therapeutics Advisory Board
- Medicaid Advisory Committee (MAC)
    - Autism Work Group
    - Community Integration, Health Equity, and Quality Care Subcommittee
    - Public Education Subcommittee
    - N.B. Stakeholder Subcommittee
- Medicaid Managed Care Oversight Commission

APPENDIX VI – ANNUAL REPORT STATUTORY REQUIREMENTS

HFS issues this Annual Report under the following statutory requirements:

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

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

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

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

Disabilities Services Act of 2003 (20 ILCS 2407/55) requires the Department to report annually on Money Follows the Person, no later than April 1 of each year in conjunction with the annual report, concerning:

- A description of any interagency agreements, fiscal payment mechanisms or methodologies developed under this Act that effectively support choice;
- Information concerning the dollar amounts of State Medicaid long-term care expenditures and the percentage of such expenditures that were for institutional long-term care services or were for community-based long-term care services; and
- Documentation that the Department has met the requirements under Section 54(a) to assure the health and welfare of eligible individuals receiving home and community-based long-term care services.