Illinois Association of Medicaid Health Plans

NEWSLETTER

THE Official Publication of IAMHP

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MESSAGE FROM THE CEO

Jill Hayden
Chief Executive Officer
Illinois Association of Medicaid Heath Plans

This summer marks 60 years since President Lyndon B. Johnson signed Medicaid into law, establishing a health care "safety net" that now covers 3.2 million Illinois residents. Since then, the program has evolved dramatically, including the shift to managed care that led to the formation of IAMHP by health plans serving Illinois.

That evolution continues. The recently signed federal budget bill brings some of the most sweeping Medicaid changes in decades.

In this newsletter, we highlight the most notable provisions in the law. For several enacted proposals, such as work requirements, we know what to expect: enrollment declines. Estimates from HFS project between 270,000 and 500,000 Illinoisians could lose coverage due to this provision alone.

The effects of other provisions in the federal budget are less certain. New restrictions on provider taxes, for example, could reduce the revenue Illinois' Medicaid program receives from the federal government by roughly $1 to $2 billion annually. Without policy solutions to close this gap, providers who mainly serve Medicaid enrollees—especially our rural and safety net partners—face an existential threat.

All this change makes the work we do at IAMHP more important than ever. By convening health plans, policymakers, providers, and advocates, we can advance solutions to protect Medicaid in Illinois and maintain momentum wherever possible. *Navigating Change*, our two-day annual conference October 27-28, will focus on exactly that. We hope you'll join us.

Indeed, there's a great deal of uncertainty about the future of Medicaid. Yet I've never been more certain about the significance of our work and the need to do everything possible to protect health care for our neighbors and their families.

Sincerely,
Jill

At a glance...

NAVIGATING CHANGE

2025 Annual IAMHP Conference

October 27-28, 2025

Hilton Chicago/Oak Brook Hills Resort & Conference Center

Oak Brook, Illinois

Presenting Sponsor:

SafeRide Health

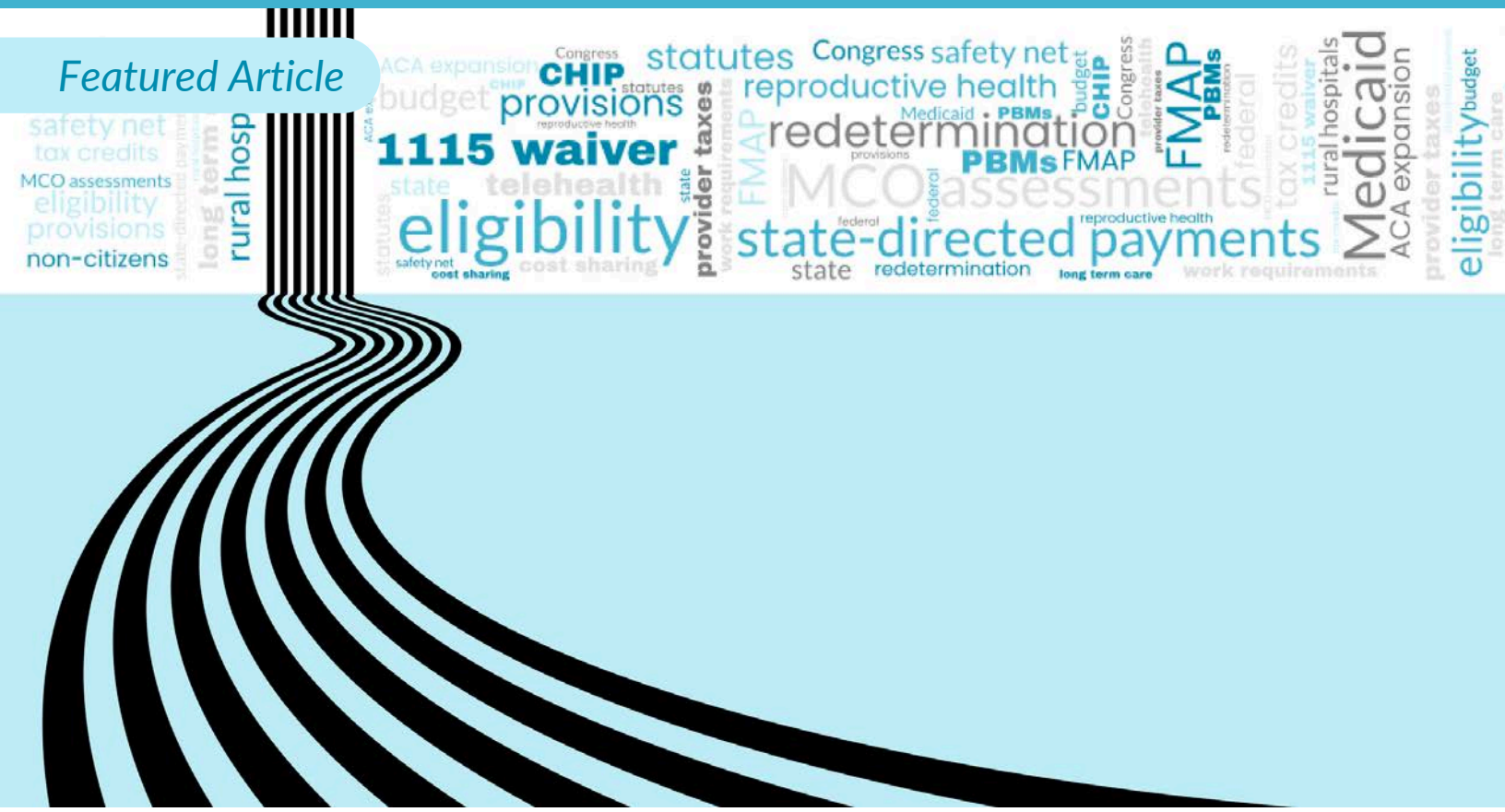
There is still time to register for IAMHP's 2025 Annual Conference, Illinois's leading event focused on advancing innovation, equity, and quality in Medicaid.

This year's theme is "Navigating Change"—a reflection of the evolving Medicaid landscape and the innovative solutions needed to meet tomorrow's challenges. Leaders from across the healthcare landscape will gather to discuss the future of Medicaid in Illinois and nationwide.

Learn more and register

- **Get the latest policy insights:** Hear directly from state leaders and policy experts on changes shaping the Medicaid landscape.
- **Network with key stakeholders:** Build relationships with health plans, providers, advocacy organizations, and state agencies.
- **Share solutions & best practices:** Participate in sessions focused on innovation, health equity, behavioral health, managed care, and more.
- **Amplify your voice:** Be part of critical conversations that influence access, quality, and equity in healthcare.
- **Earn continuing education credits:** Stay certified while gaining valuable knowledge and skills.

Featured Article



Federal Budget Reconciliation Law

Transformational legislation. A renewed call for collaboration.

The federal budget bill cuts nearly $1 trillion in Medicaid spending over the next decade. Its sweeping provisions stand to dramatically shift Medicaid policies, especially eligibility criteria and program financing. Implementation and regulatory interpretation will further dictate how the One Big Beautiful Bill Act (OBBBA) affects patients, providers, and communities.

Meeting this moment requires IAMHP stakeholders to come together with purpose and creativity. By uniting around value, prevention, and innovation, we can mitigate the law's downstream impact and safeguard essential services for millions of enrollees. Despite the foreseeable challenges, we can continue to move Medicaid forward in Illinois.

Featured Article: Impact of Federal Legislation

Peeling back provider and MCO taxes: Restrictions on a key lever of revenue

Every state except for Alaska uses provider taxes—a set percentage of net patient revenues—to help fund their Medicaid programs. The idea? By using additional dollars collected through these assessments, states can increase their share of Medicaid spending to leverage additional matching federal funds. Historically, revenues generated through this practice go directly to fee schedule updates and increased Medicaid reimbursement rates, which is why providers have tended to support these taxes.

The amount of federal matching funds each state receives is calculated using Federal Medicaid Assistance Percentages (FMAPs). States with a higher per capita income have an FMAP closer to the floor of 50% (representing an even state-federal cost share), while states with lower incomes have an FMAP as high as 76%. Illinois' FMAP is just above the floor at 51%.

Freezing Provider Taxes and Capping the Upper Limit

Effective upon its enactment July 4, 2025, the law forbids new provider taxes and prohibits increases to existing assessments.

Most concerning, though, is a phased-down cap the legislation establishes on provider tax rates, bringing the maximum allowable rate down from 6% to 3.5% of net patient revenues. **Starting in FY2028,** this "safe harbor" threshold will be reduced by 0.5% annually until the reduced cap of 3.5% is met in FY2032. Nursing homes and Intermediate Care Facilities are carved out of the reductions.

- HFS estimates federal funding losses of $4.8–11.2 billion in the first five years, starting in FY 2028—less than two years away, during the 2027 legislative session.
- Funds generated through provider taxes have historically ensured Illinois Medicaid recipients have access to services by keeping rates high enough to encourage providers to participate in Medicaid.

Requiring Uniform Tax Rates for Medicaid and Non-Medicaid Businesses

More immediate than forthcoming limits on provider taxes are new requirements around tax uniformity that will impact assessments on Medicaid health plans. The state will need to address these policy changes in the next year, as the law does not apply a phased-in approach as it does with provider tax reductions.

- Annual assessments on MCOs bring in nearly $2 billion to the Illinois Medicaid program.
- Policymakers will have to find creative solutions and work with insurers to address this change in policy and minimize the loss in critical funding.

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Featured Article: Impact of Federal Legislation

Work reporting requirements—and the hard work ahead

Medicaid work requirements are mandated work-related activities that Medicaid recipients must complete to qualify for benefits, such as working, pursuing education, participating in a work program, or volunteering. They surfaced initially during the first Trump administration, which encouraged states applying for 1115 waivers to include work and reporting requirements as a condition of Medicaid eligibility. Arkansas, which suspended these requirements in 2019, and Georgia are the only two states to have implemented work requirements. The OBBBA now mandates this policy for all states.

Research finds that the vast majority of Medicaid adults under age 65 who do not receive disability benefits are already working full- or part-time. While these individuals should theoretically meet Medicaid work requirements, efforts by states to implement such provisions have still resulted in catastrophic enrollment declines, despite spending tens of millions of dollars to build technology systems for compliance.

The reporting process has been the main driver of coverage losses, with people subject to these requirements finding the process confusing, inaccessible, or unaware of the reporting rules altogether. Adults on Medicaid are more likely to piece together multiple low-wage jobs to make ends meet. Consistently documenting proof of hours worked is especially difficult for these "gig economy" workers, people without internet access, and those with limited English proficiency.

Gearing up to require work reporting in 2027

The law requires states to implement a community engagement requirement of at least 80 hours per month by **January 1, 2027** (with the possibility to request an extension from HHS). There are carveouts for certain populations, with the most notable being adults with dependents under age 14 and individuals with disabilities. But disability exemptions can be be complicated, and advocacy groups express concern about people falling through the cracks.

The federal rules for implementation will greatly influence how work reporting requirements unfold, and the law requires CMS to issue them by **June 1, 2026**. But the OBBBA's framework indicates that, minimally:

- States must verify compliance with work requirements prior to enrollment for new enrollees, before annual redetermination, and twice annually for Medicaid expansion enrollees.
- Compliance can only be verified by state agencies, not MCOs.
- Optional short-term hardship exceptions may apply to people who are hospitalized, in residential care, part of a substance use disorder treatment program, or living in high-unemployment areas.

- Current estimates released by HFS show that between 270,000 – 500,000 Medicaid enrollees stand to lose coverage as a result of the work reporting requirement.
- Downstream impacts include more uncompensated care and a greater number of uninsured individuals presenting to providers with higher medical acuity.
- Compliance with the work reporting requirements will demand intense collaboration between state agencies, MCOs, and providers—building upon Illinois' leading work to support members with redetermination after the public health emergency.

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Featured Article: Impact of Federal Legislation

Other provisions with major state implications

Ultimately, the final bill did not reduce the enhanced FMAP for the Medicaid expansion population—averting Illinois' trigger law that would have eliminated coverage for 800,000 residents. But it does enact several proposals with significant consequences for Illinois and the other expansion states.

Removing enhanced FMAP for emergency care to non-citizens

Effective **October 1, 2026**, the OBBBA eliminates an enhanced federal match rate (90%) for emergency care delivered to non-citizen adults—people who would otherwise qualify for Medicaid through the ACA expansion if not for their immigration status. The law reverts the FMAP for all non-citizens to the state's traditional FMAP of 51%.

- Elimination of the enhanced FMAP for non-citizens will further exacerbate expected increases in the state's Emergency Medicaid costs.
- The sunsetting of Illinois' Health Benefits for Immigrant Adults (HBIA) program in June 2025 restricts undocumented immigrants' access to preventive care and treatment for low-acuity conditions—inevitably driving increased costs for Emergency Medicaid to non-citizens.

Capping state-directed payments (SDPs)

SDPs authorize insurers to enhance payment rates (sometimes up to average commercial rates) to support the financial viability of providers that serve a high proportion of Medicaid enrollees, especially critical access and safety net hospitals.

Upon enactment, the law caps new SDPs at 100% of Medicare payment levels. Starting in 2028, states with higher SDPs must begin reducing them by 10% annually until the new cap is reached.

- New SDP regulations will reduce directed payments to Illinois hospitals by about $3.4 billion over the funding reduction period.
- This loss will add pressure on already-struggling hospitals that serve many of the state's most vulnerable residents

Establishing a Rural Health Transformation Fund

The OBBBA establishes a $50 billion "Rural Health Transformation Program," a late addition to the legislation in response to bipartisan concerns about how the federal budget will affect rural hospitals.

Between FY 2026 – FY 2030, states may apply for funding with their submission of a "rural health transformation plan" to HHS. Statutory language in the bill is vague about how the funds will be awarded, with 50% to be distributed equally among approved states and the remaining portion based on forthcoming criteria from CMS.

- One in three Illinois hospitals is located in a rural area, and HFS has committed to taking swift action to apply for these funds that will be dispersed as soon as 2026.
- Experts do not expect the fund to offset rural hospitals' losses, with a Kaiser Family Foundation analysis estimating the $50 billion fund would cover just 37% of the lost Medicaid revenues projected.

The scoop from Springfield

Legislative session recap

Compared to previous years, the Illinois legislative session wrapped up May 31 with a relatively small number of policy implications for Medicaid. Anticipating cuts in the federal budget package, the state's final FY2026 budget of $55.1 billion was decreased by $300M from the budget figures introduced by the Governor in February.

Highlighted below are some of the most notable legislative updates from Springfield that may impact Medicaid stakeholders.

Restrictions on prior authorization (PA) for outpatient behavioral health (BH) services

The Healthcare Protection Act Expansion Bill (House Bill 3019) builds on PA restrictions enacted from the 2024 legislative session. Effective **January 1, 2026**, the bill introduces PA limitations on BH outpatient services and updates language in the statute related to substance use disorder (SUD) inpatient services and BH inpatient services. The law makes specific allowances for concurrent and retrospective review, and medical necessity is included among the allowable denial reasons.

The law's implications for Medicaid health plans will be relatively minimal, as most outpatient BH services were already exempted from PA requirements. To support care coordination, the bill does allow Medicaid MCOs to require notification within 24 hours of initiation of BH treatment.

Reforming Pharmacy Benefit Manager (PBM) practices

The Illinois Prescription Drug Affordability Act (House Bill 1697) assesses fees on PBMs operating in the state—$15 per member per year—and changes how Critical Access Pharmacies are reimbursed. The first $25M collected through these fees is to be used for grants to Critical Access Pharmacies.

This law gives the Department of Insurance new PBM oversight powers, including required annual audits. It also prohibits spread pricing and patient steerage, practices that are not used in Medicaid.

Other coverage mandates and regulations

Other enacted legislation, including the Medicaid omnibus package (Senate Bill 2437), introduced new policies and coverage mandates.

- **Universal mental health screening for students in grades 3 through 12** was passed through Senate Bill 1560, making Illinois the first state in the nation to require these screenings. The screenings are expected to begin in the 2027-2028 school year, and the law provides resources to train educators on the state's BEACON (Behavioral Health Care and Ongoing Navigation) portal.
- **Screening for tardive dyskinesia** is now legally required for patients prescribed antipsychotic medication in state-operated residential facilities and community-based settings.
- **Hospitals must establish policies to allow doulas** serving Medicaid enrollees to accompany patients before, during, and after labor and childbirth.
- **Diagnostic testing for Klinefelter Syndrome** must be covered by Illinois insurance plans, effective 1/1/27.
- Following federal approval and rulemaking, HFS and IDPH are authorized to develop a certification pathway for **Certified Family Health Aides**, a new category of providers for family members serving as caregivers.

Health Plan Stories of Impact

Aetna Better Health

A life-saving call for Michelle

Aetna's integrated care management (ICM) team received an urgent report that during an outreach call, Michelle*—who had no prior behavioral health history but a record of uncontrolled type 1 diabetes—sounded incoherent and was unable to provide her location. Michelle also had no stable address on file due to ongoing housing insecurity.

The team needed to identify Michelle's location immediately and send emergency services to ensure her safety.

The ICM team sprang into action. Gina, a care manager at Aetna, attempted to call Michelle back without success, while colleague Froilan searched the member file for any prior addresses. Simultaneously, Gina contacted Michelle's emergency contact while another specialist, Latoya, continued active outreach. Latoya successfully reached Michelle by phone and confirmed her address, conferencing in Gina to stay on the line. As Michelle's condition was deteriorating, Froilan contacted emergency medical services (EMS) while Latoya and Gina kept her calm until help arrived.

Aetna's teams that reach out to members with housing insecurity found that Michelle, who has a history of uncontrolled diabetes, was disoriented and incoherent when she answered their phone call. Care managers sprang into action to find her location and send emergency medical services.

EMS transported Michelle to the ER, where she was treated for diabetic ketoacidosis—a life-threatening emergency. The following day, Latoya re-established care management with Michelle, who expressed deep gratitude and agreed to work on managing her diabetes. Michelle later said, "Latoya and her team saved my life."

The stories that inspire us

Visit our website for more examples of the impact our member health plans are having on the lives of their members

*For privacy and HIPAA compliance, member names have been changed.

Health Plan Stories of Impact

Blue Cross Blue Shield of Illinois

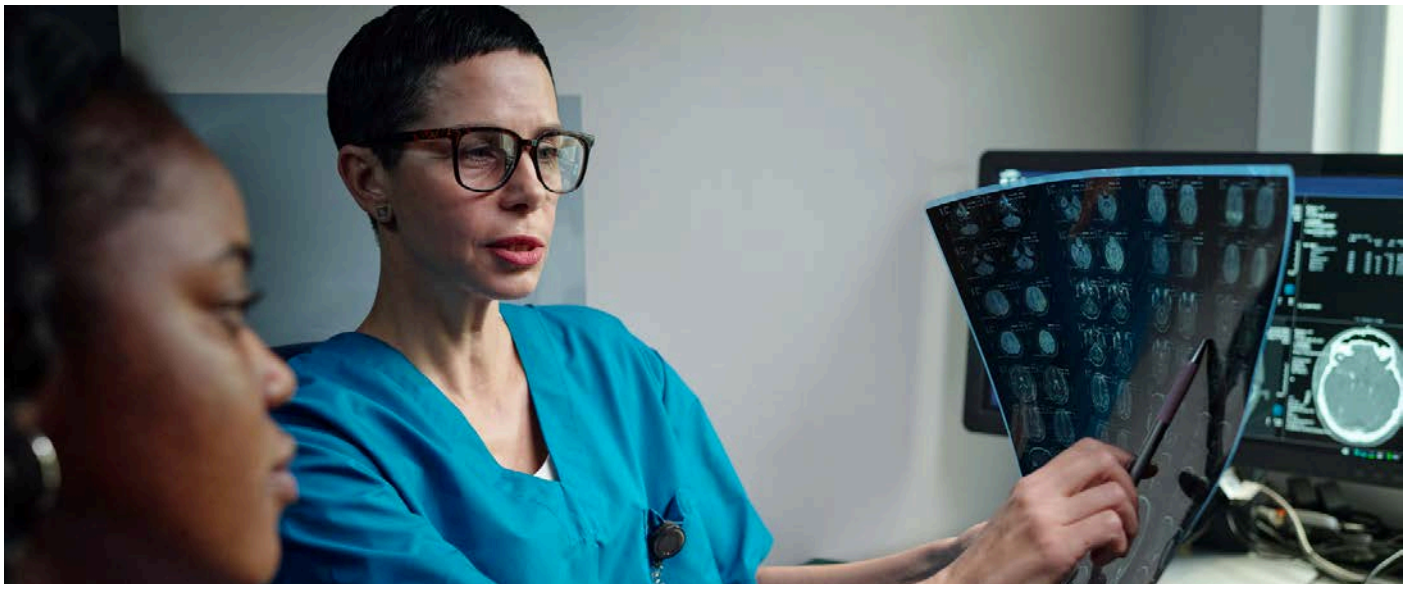
Helping Taneka discover new hope with specialized neurology care

Taneka*, a 31-year-old member living in DuPage County, has been managing a rare neurological condition called mitochondrial disorder since she was a teenager. Although she had a personal assistant through the Department of Rehabilitation Services and support from her family, Taneka had not seen a neurologist familiar with her condition since her original pediatric specialist. For over 13 years, her family had struggled to find a provider who understood how to treat her specific diagnosis. Most doctors she saw focused only on treating her related conditions and avoided addressing the disorder itself.

While supporting another member with muscular dystrophy, a Blue Cross Blue Shield case management specialist realized that mitochondrial disorders fall within the same clinical category. That discovery sparked new hope. The case manager began making calls to several organizations, including the Muscular Dystrophy Association, the Mitochondrial Disorder Support Association, and the University of Illinois Muscular Dystrophy Clinic.

After thorough outreach, the Case Management Specialist found a neurologist near Taneka's home who specializes in mitochondrial disorders. They worked with the her primary care provider to secure the necessary referral and arranged transportation for Taneka, her mother, and her service dog to make the visit possible. They also supported Taneka's mother, who serves as her power of attorney, in navigating the appointment scheduling process.

Now, for the first time in over a decade, Taneka and her family are feeling hopeful. They are excited to meet with a provider who understands her condition and look forward to following a care plan tailored to her needs.



For 13 years, Taneka and her family struggled to navigate the transition from pediatric to adult care for her rare neurological disorder. With help from a Blue Cross Blue Shield Care Manager, they've connected to a new brain health specialist committed to developing a care plan tailored to Taneka's unique condition.

**For privacy and HIPAA compliance, member names have been changed.*

Health Plan Stories of Impact

CountyCare

Supporting Ashley's development and reducing financial burdens for her mom

Ashley* is a 4-year-old CountyCare member with autism. Ashley is highly sensitive to food textures, making it difficult for her to eat. During an appointment with her primary care provider (PCP) the family and care team discussed concerns regarding Ashley's development. A treatment discussed was adding PediaSure, a nutrient-dense and caloric-filled drink, to Ashley's diet.

Over the next several months, Ashley's mom was thrilled that her daughter took so well to PediaSure, but was concerned about the ongoing costs of the nutritional supplement, as it was one of the few things Ashley tolerated. She shared her financial concerns with her CountyCare care coordinator, who told her that since PediaSure was medically necessary, it could be covered by the health plan with a prescription from Ashley's PCP.

Ashley's mom reports that she obtained the prescription and is thankful for the financial relief and monthly shipments of PediaSure. More importantly, she is thrilled to see her daughter developing and thriving.

Ashley, age 4, wasn't getting the nutritional intake she needed to develop because of severe sensory sensitivities associated with autism. When she responded positively to PediaSure drinks recommended by the care team, the care coordinator for Ashley's family made sure these medically necessary supplements were covered.

Health Plan Stories of Impact

Humana

Rebuilding trust in healthcare and promoting Juliana's independence through compassionate care coordination

Background: After nearly a year of trying without success, Humana reached 54-year-old member Juliana* by phone in February 2025. She quickly opened up to Sue, her assigned care coordinator.

"My apartment has become my island," Juliana said. "I haven't left it in 3 years, and I never leave this chair except to use the bathroom or microwave food. I saw my doctor about a year ago, and the doctor was not very happy with me and my weight. I felt (fat) shamed and never went back. I can only walk a few steps with a walker, and I can hear my knees crushing and cracking from my weight."

In addition to morbid obesity, Juliana has vitiligo on her hands and face, which she said added to her shame when leaving the house. Sue sympathized with the member and focused on building trust. Juliana asked Sue if she had ever seen the reality TV series "Hoarders" and self-identified with people featured on the show. Her friend Mary was with her during the call and noted her efforts to help clean Juliana's apartment to the best of her ability.

When asked about her biggest concerns, at the top of Juliana's list was getting help at home with activities of daily living and seeing a psychiatrist for depression. Juliana shared that depression had worsened her agoraphobia, and though she had previously seen a psychiatrist, she did not like him and stopped going.

Juliana also reported fears of falling due to arthritic discs, painful knees, and painful swelling on her right side. She disclosed additional hygiene issues resulting from her inability to shower independently. While her friend Mary is a certified nurse's aide who helps her with getting up and prepping healthy meals, Juliana acknowledged that she could use "all the help I can get in the home."

Interventions: Sue praised Juliana for her candor, assuring her that there is no reason to be ashamed of sharing her story. Sue continued to provide reassurance that together with the social work team, Humana can provide additional resources to support her.

Sue first verified with Juliana that her house is currently clean and clutter-free thanks to Mary's assistance, allowing Juliana to move freely around as needed without the risk of falls. Sue offered to refer Juliana to Anita, a nurse care manager who could assess needs, follow up more frequently, and offer face-to-face assessment. Sue educated Juliana on Humana's member resources and assistance related to medical appointments and transportation. Sue also educated Juliana on Humana's partner, Carelon, and the importance of initiating a consultation for a psychiatrist, to which she agreed.

Sue collaborated with social worker Evelyn following the call, who connected with Juliana and formally assessed her needs. Evelyn then referred her to the Department of Rehabilitation Services for in-home support through a waiver program.

Outcomes: Sue was able to build rapport with Juliana and re-engage her in follow ups. With social worker Evelyn, Juliana has initiated the process for in-home waiver services. She has received a list of psychiatrists from the Carelon consultation and has been assigned to a nurse care manager who is better suited to work with her based on her current needs. Once Juliana's top two priorities were addressed, she agreed to a follow-up call with Anita, who was able to complete a health risk assessment and further assist Juliana.

Health Plan Stories of Impact

Meridian

Continued persistence in caring for Daniel

Meridian member Daniel* was born 11 weeks prematurely. Additionally, he had three major surgeries before turning 3 years old. As a result, Daniel was on IV drips for nine months post-surgery. All of that took a toll on his immune system. Over the years, Daniel has had multiple lung issues, including COPD and 50+ bouts of pneumonia. Anytime he contracted pneumonia, Daniel would have to go to the ER, as he needed IV antibiotics. He could not get an IV placed without an ultrasound due to the multiple medical issues he faced.

Daniel's latest hospital trip resulted in sepsis and pneumonia. The hospital had trouble inserting an IV, as he was down to one good vein that could hold an IV needle. The hospital placed a midline, hoping it would last for 30 days. Unfortunately, it collapsed in two days.

When providers struggled to administer IV medications for Daniel, they recommended a central access port. The Meridian team stepped up to help his family with the ongoing care related to the port.

With no other options left, Daniel had to have a PICC line, or peripherally inserted central catheter, inserted during his hospital stay. The PICC line worked, but knowing he would need medications long term, doctors advised him to switch to a port instead. A port can be used for years to administer medications before needing replacement. A key consideration, though, is that ports need to be flushed every 28 days.

Once Daniel was healthy enough to go home, his mom began making calls. Michael, a Meridian Program Specialist, was the supervisor in charge of escalations. Daniel's case made its way to his desk. As Michael read Daniel's mom's email, he knew he had to help. As a dad himself, he could relate to parents in such difficult situations.

Michael contacted the Utilization Management department to determine why the flush procedures were not approved for Daniel. He spoke to colleagues and realized a provider coding error on the authorization was causing the denial. Michael worked with Daniel's mom to get all the paperwork resubmitted, including physicians' letters and notes from the multiple hospital stays. He stamped it all as "URGENT" to get it processed quickly.

The next day, Michael called back and got the flush approved. He immediately phoned Daniel's mom, who was so happy and relieved that she cried. As a result of Michael's dedication, Daniel now has a process for getting his port flushed every 28 days to keep it working correctly.

With his port in place, Daniel has received the necessary medications to prevent infection and pneumonia. He has not required a hospital stay in months thanks to his port. And now, thanks to his Meridian care manager, Daniel has someone who checks in on him every month and is ready to help.

**For privacy and HIPAA compliance, member names have been changed.*

Health Plan Stories of Impact

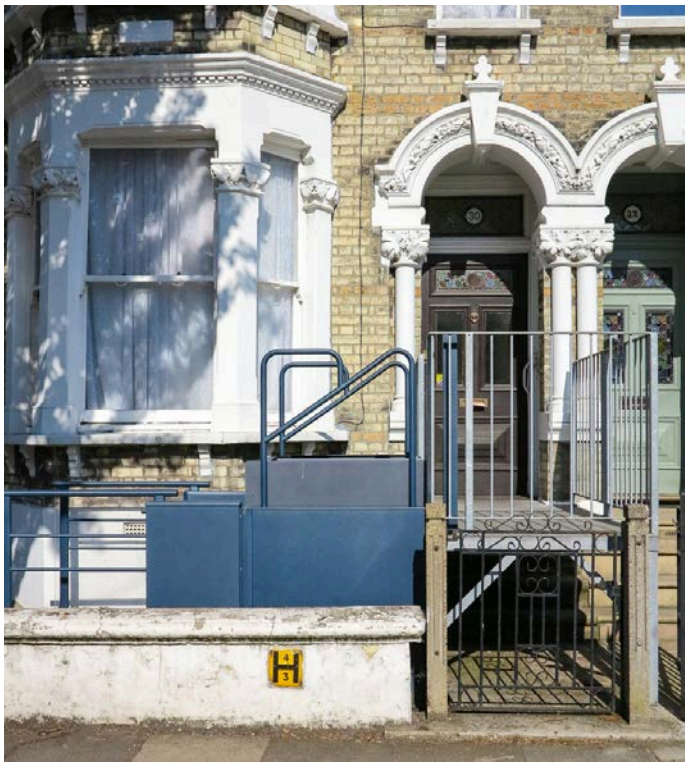
Molina Healthcare

Creating an on-ramp for John's increased community mobility

Meet John: John* is a 38-year-old resident of Cook County. He is wheelchair dependent due to paraplegia and spina bifida, and although he faces many challenges from his medical condition, John has a resilient and determined spirit. John lives at home with his mother and personal assistant who helps care for him. However, the lack of an accessible ramp at home made each outing physically demanding for John and his caretakers and significantly limited his ability to leave the house safely. John had to be carried down the stairs, creating risks for falls and injuries—both for him and caregivers—which prevented John from attending medical appointments.

Getting Help: John's Molina case manager immediately recognized that the lack of accessible home entry posed a safety hazard. The case manager provided John and his mother with thorough education about home modification options, guidance on eligibility, application steps, and potential solutions. Recognizing limitations due to the member's yard size and city codes, the case manager explored alternative solutions to a traditional ramp and secured approval for an electric lift, which would best fit John's needs and ensure he had a safe, accessible way to leave his home and reclaim his mobility.

Now: Molina's dedicated and compassionate case manager transformed not just John's access to care, but also his quality of life for the better. By proactively listening to John's barriers, needs, and desires, the case manager created and executed a personalized plan that helped restore John's independence. John can now safely use his power chair to attend medical appointments, complete daily errands, and enjoy time out in the community—without the risks and restrictions he once faced. John stated enthusiastically, "I will be able to go all over town now that I have the lift."



John, a wheelchair user motivated to get out into the community, was struggling to leave his house safely due to accessibility issues. His Molina case manager helped support him with home modifications covered by Medicaid, ultimately helping John get an electric lift that was workable for his Chicago-area home.

**For privacy and HIPAA compliance, member names have been changed.*

2025 TRUSTED PARTNER MEMBERS

Warmly welcoming a cohort of brand-new Trusted Partners

Throughout 2025, IAMHP has been thrilled to introduce several new Trusted Partners to our community of Medicaid managed care stakeholders. Take a moment to learn about these impressive organizations and the benefits of becoming an IAMHP Trusted Partner.

Backpack Healthcare believes that all children, young adults, and their families deserve fast access to life-changing mental health care and much-needed resources. Their AI powered mental health self-care app helps monitor emotions, utilizes custom bibliotherapy education and tools, and helps identify those who would benefit from entering therapeutic services. They also provide pediatric and family therapy, as well as parent training.

FreedomCare brings joy and comfort to seniors and disabled people by empowering them to stay in their homes. They are a leading in-home provider for patients and their caregivers. FreedomCare provides Medicaid members with the power to select their caregiver and get them reimbursed, whether they're hiring a family member, friend, or previously hired aide.

Help at Home is a trusted partner to families across the country, providing compassionate care that allows individuals to maintain independence and dignity at home. They started as a small operation in Evanston, IL, but have grown into the country's largest personal care services organization. Their person-centered services create Great Days and Meaningful Moments for individuals while driving high-quality, low-cost outcomes. They provide in-home, community-based care in 11 states and 200 locations with the help of 60,000 highly trained, compassionate caregivers who have relationships with 70,000+ clients monthly.

Imagine Pediatrics provides 24/7 virtual and in-home care for children with special health care needs. Their multidisciplinary, pediatrician-led care team works with a child's current doctors to expand access to the support that they need, day or night and right from home. They leverage existing health plan benefits to provide access to more of the integrated medical, behavioral, and social support that children with special health care needs deserve.

Marigold Health is a secure, anonymous network where people with mental health and substance use conditions support and motivate one another on their recovery journeys. Members have access to wellness and goal planning, recovery capital tools, peer support, and theme-based chat groups. Some members receive one-on-one support from a certified Peer Recovery Coach with lived experience who is trained to support their recovery using a data-driven approach, including Natural Language Processing, to make sure the areas of highest need across their app are supported.

Master Care's knowledge and experience working with thousands of clients and their families during the transitional challenges that affect older adults make them uniquely qualified in understanding the nuances of different types of senior living—positioning them to carefully match client needs with highly specialized senior living providers or appropriate in-home caregivers. Their database, platform, and processes allow them to be as efficient as possible while their vast experience, training, and support enable the hands-on, labor-intensive practice of safe and successful transitioning.

MedReview's highly trained physicians representing every medical specialty apply their skills in working with registered nurses and certified coders to identify inaccurate claims and perform comprehensive clinical reviews— reducing unnecessary waste and saving billions of dollars for their clients. As a physician-led organization with an extensive staff of board-certified physicians, specialists, and nurses, they employ tight quality control throughout the review process and ensure every reassignment is reviewed by a physician. Proprietary algorithms automatically make sense of the ocean of complex, messy data that comes with healthcare claims, recognizing suspicious payment trends and targeting claims with the highest potential for waste and abuse.

MedScope is a division of Medical Guardian dedicated to serving Medicaid partners and their members. They pride themselves on being the leading provider of Personal Emergency Response Systems & Engagement Services for Long-Term Services & Support (LTSS) and Home-Based Community Services (HBCS). With over 25 years of experience across 47 states, their dedicated team tailors every solution to meet the unique needs of each organization while upholding the highest standards of quality care.

Mercato makes healthy eating simple and accessible for everyone through the power of technology. Their platform provides customers access to healthy, nutritious, and culturally appropriate foods, especially in historically vulnerable and high-need communities. Customers can shop online with any combination of public and private payment options or benefits, including SNAP/EBT, Medicaid, and Medicare Advantage, for a simplified and stigma-free experience.

Founded in 2006, **Morreale Communications** was designed with a unique blend of journalism, government, media, and creative services to provide innovative strategic solutions for a wide variety of clients in the public and private sectors. They are dedicated to operating as a strong advocate for diverse voices and are a certified WBE/BEP/WBENC/DBE firm, with an 85% female and minority workforce. Morreale's dedication to diversity and inclusion is not limited to its internal operations. They ensure all populations impacted by clients and their projects are provided meaningful opportunities to help shape project outcomes.

A new platform for building bridges

Trusted Partner Showcase Recap

On June 24 and 25, IAMHP hosted its first-ever Trusted Partner Showcase, a two-day virtual event bringing together a total of 22 IAMHP Trusted Partners and our member MCOs.

The event format gave each Trusted Partner the chance to deliver a 15-minute presentation—touching on their businesses' backgrounds, missions, and value propositions—to MCO executives and organizational development leads in attendance. All Trusted Partners were welcome to join the event, also enabling organizations invested in Medicaid to learn more about one another.

The opportunity to present at the showcase was a new benefit added to the 2025 Trusted Partner Program, which aims to improve organizations' access to industry news about managed care and help promote their offerings to other Medicaid stakeholders. With health plans considering federal policy changes and new opportunities in Illinois, now was the ideal time to launch this program, explained Rachel Thomas, IAMHP's Director of Operations and Strategic Initiatives.

"Each of our Trusted Partners is doing meaningful work and demonstrates a commitment to managed care through their affiliation with IAMHP," Thomas said. "We were motivated to create a platform for them to showcase their capabilities, inspire new ideas, and build connections."

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UPCOMING COMPLIMENTARY WEBINARS

IAMHP's complimentary webinars cover timely topics in the industry and are available at no cost to interested participants. Look for more 2025 webinars to be added to our calendar and check out a recent presentation you may have missed!

Sept. 10 at noon

Beyond Medicine: AbsoluteCare's Model for Managing Vulnerable Populations
presented by AbsoluteCare

Register

Oct. 1 at noon

The MCO's Role in Assisted Outpatient Commitment with the Illinois Courts
presented by Illinois Courts

Register

Oct. 8 at noon

Final Recommendations for Supporting Community-Based Organizations
presented by the Illinois Public Health Institute

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