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State/Territory Name: IL

State Plan Amendment (SPA) #: 13-015

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

December 13, 2013

Julie Hamos, Director
Illinois Department of Healthcare and Family Services (HFS)
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ATTN: Theresa Eagleson

RE: TN 13-015

Dear Ms. Hamos:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA).

Transmittal #13-015 - Approves Illinois' request to implement a voluntary managed care program as part of the Medicare-Medicaid Alignment Initiative.

--Effective Date: February 1, 2014

If you have any questions, please have a member of your staff contact Cathy Song at (312) 353-5184 or by email at Catherine.Song1@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Mary Doran, HFS
Beth Green, HFS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER: **13-015**

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: **Title XIX of the *Social Security Act* (Medicaid)**

4. PROPOSED EFFECTIVE DATE: **February 1, 2014**

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932(a) of the *Social Security Act*

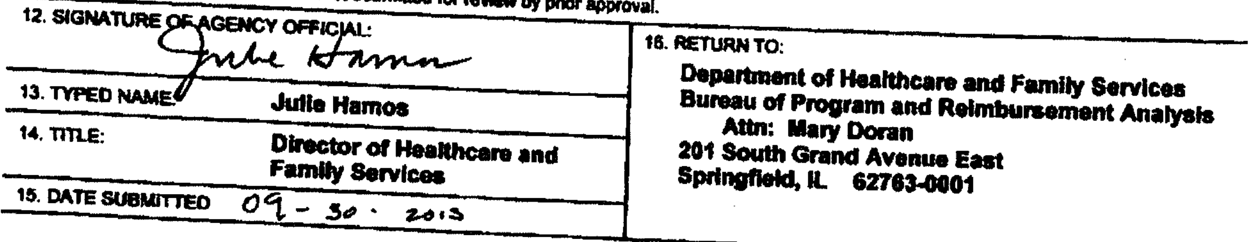
7. FEDERAL BUDGET IMPACT
a. FFY 2013 $600 Million
b. FFY 2014 $900 Million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, Pages 45 through 58

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New Pages

10. SUBJECT OF AMENDMENT:
Medicare & Medicaid Alignment Initiative

11. GOVERNOR'S REVIEW *(Check One)*
[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.



12. SIGNATURE OF AGENCY OFFICIAL: Julie Hamos

13. TYPED NAME: **Julie Hamos**

14. TITLE: **Director of Healthcare and Family Services**

15. DATE SUBMITTED: 09-30-2013

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Mary Doran
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/30/13

18. DATE APPROVED: 12/13/13

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 2/1/14

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Verlon Johnson

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
1932(a)(1)(A)	A. Section 1932(a)(1)(A) of the Social Security Act.

The Centers for Medicare & Medicaid Services (CMS) and State of Illinois will establish a Federal-State partnership to implement the Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees). The Federal-State partnership will include a Three-way Contract with Demonstration Plans that will provide integrated benefits to Medicare-Medicaid Enrollees in the targeted geographic areas. The Demonstration will begin on February 1, 2014 and will continue until December 31, 2017. The initiative is testing an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for Medicare-Medicaid Enrollees, enhance quality of care, and reduce costs for both the State and the Federal government. The Demonstration will be voluntary with passive enrollment of those Medicare-Medicaid Enrollees that do not select a health plan. Participants can opt out of the demonstration at any time. Passive enrollment will be in compliance with the requirements of 42 CFR 438.50 (f), "enrollment by default" - for recipients who do not choose an MCO during their enrollment period, the State must have a default enrollment process for assigning those recipients to contracting MCOs.

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

☑ i. MCO
☐ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
☐ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

☐ i. fee for service;
☑ ii. capitation;
☐ iii. a case management fee;
☑ iv. a bonus/incentive payment;
☐ v. a supplemental payment; or
☐ vi. other. (Please provide a description below).

Bonus/Incentive Payment- Quality Withhold:
Both CMS and the Department will withhold a percentage of their respective components of the Capitation Rate, with the exception of the Part D Component amounts. The quality withhold will be 1% of the capitation in the first year of the demonstration. This amount will

Citation	**Condition or Requirement**
	increase to 2% in the 2nd year and 3% in the 3rd year. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds. Additional details, including technical specifications, withhold methodology and required benchmarks, are to be provided in subsequent demonstration guidance.
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ☐ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ☐ ii. Incentives will be based upon specific activities and targets. ☐ iii. Incentives will be based upon a fixed period of time. ☐ iv. Incentives will not be renewed automatically. ☐ v. Incentives will be made available to both public and private PCCMs. ☐ vi. Incentives will not be conditioned on intergovernmental transfer agreements. ☑ vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* The State began stakeholder engagement in the planning of managed care programs for the Seniors and Persons with Disabilities (SPD) populations in April 2010. Since then, the State held 16 planning meetings with stakeholders specific to managed care development and engaged stakeholders in topics pertinent to the development of a managed care program including consumer direction, quality outcomes and measurement, care management, enrollment, and provider networks. Examples of stakeholder feedback and lessons learned that

Citation	**Condition or Requirement**

informed the development of the demonstration include a greater emphasis on ensuring consumer direction not only with respect to personal assistants but with respect to all services; to ensure network adequacy before implementation of the demonstration; to require Demonstration Plans to work with providers to meet ADA compliance; and to ensure continuity of care as beneficiaries are transitioned into the program.

Of the 16 planning meetings, three of the stakeholder meetings were held during the public comment period for the draft demonstration proposal (February 17 – March 19, 2012) in several cities in the geographic target areas. During these meetings the State engaged stakeholders on topics pertinent to the development of the demonstration including the passive enrollment process, network adequacy, and excluding individuals receiving developmental disability institutional or community-based waiver services from enrollment in the demonstration,.

The State will continue to meet with stakeholders throughout the operation of the demonstration through regularly scheduled meetings with the SPD stakeholders group focusing on the demonstration. A SPD stakeholder group meeting was held on April 18, 2013, and additional meetings are scheduled for each quarter through 2014.

The State also holds stakeholder meetings at least quarterly through the Medicaid Advisory Committee (MAC) and the MAC Care Coordination Subcommittee. At these meetings, the State provides updates on the planning and implementation of the demonstration and other initiatives and continues to receive stakeholder feedback on its efforts. In addition to stakeholder meetings, the State uses its website to post pertinent information related to the demonstration (http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx) and maintains an email box to be able to respond to questions and comments related to the demonstration and the other initiatives the State is pursuing (HFS.carecoord@illinois.gov).

The State also consulted with the American Indian Health Services of Chicago (AIHSC) to ensure the American Indian / Alaska Native population is aware of the demonstration and the possible changes to the delivery of care for American Indians / Alaska Natives who are dual eligible beneficiaries. Under the State's tribal consultation process, the State contacted the American Indian Health Services of Chicago (AIHSC) on September 12, 2013, to notify them of the State's intention to submit this SPA, the details of the SPA, and the expected impact on American Indians / Alaska Natives and provided a two-week comment period. The State did not receive comments during the comment period.

Citation	Condition or Requirement
1932(a)(1)(A)	5. The state plan program will ☐ /will not ☑ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ☐ / voluntary ☑ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) ii. county/counties (voluntary) <u>Greater Chicago Region:</u> Cook, DuPage, Kane, Kankakee, Lake, Will <u>Central Illinois Region:</u> Champaign, Christian, DeWitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell, Vermilion,. iii. area/areas (mandatory)__________ iv. area/areas (voluntary)__________
	C. <u>State Assurances and Compliance with the Statute and Regulations.</u> If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ☑ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☐ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ☑ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. ☑ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

State: **Illinois**

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. ☑ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ☑ The state assures that all applicable requirements of 42 CFR 438.6 (c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(6)	7. ☐ The state assures that all applicable requirements of 42 CFR 447.362 for 42 CFR 447.362 payments under any non-risk contracts will be met.
45 CFR 74.40	8. ☑ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. <u>Eligible groups</u>
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. No eligibility group will be required to enroll, the Demonstration will be voluntary with passive enrollment of those individuals receiving both Medicare and Medicaid services that do not select a health plan. Individuals can opt-out of the program at any time.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ☑ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. Individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees) in the targeted geographic areas will be allowed to voluntarily enroll in the Demonstration, with passive enrollment of those that do not select a health plan. Participants can opt out of the demonstration at any time, even prior to enrollment if desired.
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ☑ Indians who are members of Federally recognized Tribes. The Demonstration is a voluntary program, therefore no Indians who are members of Federally recognized Tribes are mandated to enroll, however they may choose to voluntarily enroll or remain enrolled.

Citation	**Condition or Requirement**
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ☐ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ☐ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ☐ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ☐ Children under the age of 19 years who are receiving Foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ☐ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
	E. <u>Identification of Mandatory Exempt Groups</u>
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* Not applicable. The Demonstration does not include enrollment of children.
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: ☐ i. program participation, ☐ ii. special health care needs, or ☐ iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. ☐ i. yes ☐ ii. No

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* Not applicable. No children will be enrolled in the Demonstration. i. Children under 19 years of age who are eligible for SSI under title XVI; Recipient database and self-identification. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; Recipient database and self-identification. iii. Children under 19 years of age who are in foster care or other out-of-home placement; Recipient database and self-identification. iv. Children under 19 years of age who are receiving foster care or adoption assistance. Recipient database and self-identification.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* Not applicable
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. Recipient database. ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. Recipient database and self-identification.
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> Not applicable.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis. The Demonstration is voluntary; therefore all Medicare-Medicaid Enrollees will be permitted to voluntarily enroll. H. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). Existing provider-recipient relationships will be considered based on historical claims data and requests by the recipient. ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). The Department provided information to the Demonstration plans of the providers that have historically served this population, based on claims data. The Demonstration plans began with this list but have since targeted all Medicare and Medicaid enrolled providers to join their plans as PCPs and specialists. iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)* Medicare-Medicaid Enrollee who do not select a health plan will be auto-assigned to an MCO by the Illinois Client Enrollment Services (ICES). Individuals who opt out of the Demonstration

Citation	**Condition or Requirement**
	will not be included in Passive Enrollment for the remainder of the Demonstration. The ICES will develop and apply an intelligent assignment algorithm, to the extent approved by CMS. CMS will provide Illinois with historical Medicare data for the development of the algorithm. The algorithm will consider Eligible Beneficiaries' previous managed care enrollment and historic provider utilization, including Medicare providers and service utilization, to assign Medicare-Medicaid Enrollees to a Demonstration plan. CMS and the Department may stop passive enrollment to a specific demonstration plan if the demonstration plan does not meet reporting requirements necessary to maintain passive enrollment as set forth by CMS and the Department. Passive enrollment will be effective no sooner than May 1, 2014. There will be a passive enrollment phase-in period not exceed 5,000 individuals per demonstration plan per month in the Greater Chicago region and no more than 3,000 individuals per demonstration plan per month in the Central Illinois region. The initial passive enrollment period will occur over at least a six (6) month period. CMS and the Department will monitor the roll-out of the passive enrollment and may adjust the volume and spacing of passive enrollment periods, and will consider input from the demonstration plans in making any such adjustments.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: i. The state will ☐ / will not ☑ use a lock-in for managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be <u>60</u> days. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* During the enrollment process, potential enrollees will be sent an explanatory letter, an initial enrollment packet and a second enrollment letter. The second enrollment letter will specify the demonstration plan (MCO) to whom the potential enrollee will be assigned if no choice is made. If no choice is made and a client is enrolled through passive enrollment, the MCO will send a welcome packet to the enrollee that includes all basic information, including an explanation of the Demonstration, a summary of important topics, such as how to get needed care, a benefits summary, and information about the complaint, grievance and appeal processes.

Citation	**Condition or Requirement**

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

During the enrollment process, potential enrollees will receive an information guide from the Illinois Client Enrollment Services. This information guide will provide information regarding disenrollment rights.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

The ICES will develop and apply an intelligent assignment algorithm. CMS will provide Illinois with historical Medicare data for the development of the algorithm. The algorithm will consider Eligible Beneficiaries' previous managed care enrollment and historic provider utilization, including Medicare Providers and service utilization, to assign Medicare-Medicaid Enrollees to a Demonstration health plan. CMS and the Department may stop passive enrollment to a specific health plan if the health plan does not meet reporting requirements necessary to maintain passive enrollment as set forth by CMS and the Department.

Passive enrollment will be effective no sooner than May 1, 2014. There will be a passive enrollment phase-in period not exceed 5,000 individuals per plan per month in the Greater Chicago region and no more than 3,000 individuals per plan per month in the Central Illinois region. The initial passive enrollment period will occur over at least a six (6) month period. CMS and the Department will monitor the passive enrollment process, and may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the health plans in making any such adjustments.

The assignment algorithm may take into consideration:

- Current assignment to a Medicare Advantage health plan
- Existing provider-client relationship based on claims data.
- The geographic location of the client and PCP.
- Special needs of the client, if known.
- Capacity limits set by CMS, HFS or the provider.
- Provider panel status.

Citation	Condition or Requirement

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

On a monthly basis, the Illinois Client Enrollment Services will report to the Department Potential Enrollees who have voluntarily chosen a health care delivery system and PCP, Potential Enrollees who are enrolled by passive enrollment, and Enrollees who request to opt out of the Demonstration, or change from one Demonstration plan to another Demonstration plan. In addition the Department will produce ad-hoc reports as necessary.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. ☑ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. ☑ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   ☑ This provision is not applicable to this 1932 State Plan Amendment.

4. ☐ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   ☑ This provision is not applicable to this 1932 State Plan Amendment.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
	5. ☑ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.
	☐ This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.50	J. Disenrollment
	1. The state will ☐ /will not ☑ use lock-in for managed care.
	2. The lock-in will apply for 0 months (up to 12 months).
	3. Place a check mark to affirm state compliance.
	☑ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).
	4. Describe any additional circumstances of "cause" for disenrollment (if any).
	Not applicable. An Enrollee may request to disenroll from the Demonstration at any time for any reason.
	K. Information requirements for beneficiaries
	Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	☑ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM)
	All medically necessary services provided under Medicare Part A, Part B and Part D, and all services provided under Illinois State Plan excluding ICF/MR services, are included in the Demonstration, unless otherwise excluded or limited below. Also included are all Home and Community Based Waiver Services for individuals on the following waivers: Persons who are Elderly; Persons with Disabilities; Persons with HIV/AIDS; Persons with Brain Injury; and Supportive Living Facilities Waiver.

Citation	**Condition or Requirement**

Special requirements regarding the Medicare hospice benefit:

If an Enrollee elects to receive the Medicare hospice benefit, the Enrollee may remain in the Demonstration Plan, but will obtain the hospice service through the Medicare FFS benefit and the Demonstration Plan would no longer receive the Medicare Parts A/B Component for that Enrollee. Medicare hospice services and hospice drugs and all other Original Medicare services would be paid for under Medicare FFS. Demonstration Plans and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care. The Demonstration health plan would continue to receive the Medicare Part D Component for all non-hospice covered drugs. Election of hospice services does not change the Medicaid Component. For Enrollees electing hospice services while residents of a NF, the Medicaid payment to the hospice provider for the "room and board" component will be the responsibility of the MCO.

Specific Illinois State Plan services that are excluded include:

- Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment;
- Services that are provided through a Local Education Agency (LEA);
- Services that are experimental or investigational in nature;
- Medical and surgical services that are provided solely for cosmetic purposes; and
- Diagnostic and therapeutic procedures related to infertility or sterility.

The following services and benefits are limited as Covered Services under the Illinois State Plan:

Termination of pregnancy may be provided only as allowed by applicable State and federal law (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be fully complied with and HFS Form 2390 must be completed and filed in the Enrollee's medical record.

Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a HFS Form 2189 must be completed and filed in the Enrollee's medical record.

If a hysterectomy is provided, a HFS Form 1977 must be completed and filed in the Enrollee's medical record.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

MANDATORY ENROLLMENT IN MANAGED CARE ENTITIES

Citation	Condition or Requirement
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will ☑ /will not ☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ☑ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   The Department held a competitive procurement for health plans to participate in the Demonstration. The number of plans needed to participate in each region was determined and awards were made accordingly. There are six MCOs in the Greater Chicago region and two MCOs in the Central Illinois region.

4. ☐ The selective contracting provision is not applicable to this state plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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