Table of Contents

State/Territory Name: IL

State Plan Amendment (SPA) #:14-0041

This file contains the following documents in the order listed:

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

March 12, 2015

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

ATTN: James Parker

RE: TN IL-14-0041

Dear Ms. Norwood:

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

Transmittal #IL-14-0041 - Alternative Benefit Plan (ABP) amendment to realign the ABP services to those available under the state plan. Therefore, this SPA revised limitations to podiatric, dental, physical therapy, occupational therapy and speech therapy services.

-Effective Date: July 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/

Alan Freund
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

cc: Gabriela Moroney, HFS
Mary Doran, HFS
Teresa Hursey, HFS
Sara Barger, HFS

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Illinois**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IL-14-0041

Proposed Effective Date

07/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Social Security Act 1937; 42 CFR Part 440

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$0.00
Second Year	2015	$0.00

Subject of Amendment

This amendment updates the benefits description and service delivery system forms for the Alternative Benefit Plan for ACA Adults in Illinois to preserve full alignment with the state plan.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  The Governor has authorized the director of Healthcare and Family Services to act as his designee to review, approve and submit state plan amendments under Title XIX of the Social Security Act. The director has reviewed this submission and has no comments.

Signature of State Agency Official

Submitted By:	**Gabriela Moroney**
Last Revision Date:	**Mar 11, 2015**
Submit Date:	**Dec 30, 2014**

DATE RECEIVED
12/30/2014

DATE APPROVED:
03/12/15

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/2014

SIGNATURE OF REGIONAL OFFICIAL:
/s/

TYPED NAME
Alan Freund

TITLE:
Acting Associate Regional Administrator

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: ACA Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- [ ]

OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	**ABP2a**

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

The State has compared the services covered by its Medicaid state plan with the services covered by its selected base benchmark plan. Services covered by base benchmark but not the Medicaid state plan were excluded from the ABP through the appropriate substitution process. Specific details are captured in ABP 5.

PRA Disclosure Statement

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: ACA Adult Alternative Benefit Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ◉ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ○ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Illinois is including all of the benefits from the approved state plan and no additional benefits.

Selection of Base Benchmark Plan

Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (●) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: Blue Cross Blue Shield BlueAdvantage Entrepreneur

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Alternative Benefit Plan Cost-Sharing	ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 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.

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

BlueCross BlueShield of Illinois BlueAdvantage Entrepreneur PPO

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved.

Alternative Benefit Plan

■ Essential Health Benefit 1: Ambulatory patient services — Collapse All ☐

Benefit Provided: Outpatient hospital services

Source: State Plan 1905(a) — Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 2a from state plan. Prior authorization is required for a limited array of devices and practitioner administered drugs.

Benefit Provided: Family planning services and supplies

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 4c from state plan.

Benefit Provided: Physician services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: See below

Duration Limit: See below

Scope Limit: See below

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Items 5a and 5b from state plan; includes medical and surgical services furnished by a dentist.
Authorization requirements and limits apply in certain circumstances:
-Prior approval is required for surgeries for morbid obesity.
-Group psychotherapy services rendered by a physician are subject to program integrity controls.

Remove

Benefit Provided: Podiatrists' services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 6a from state plan.

Covered services are limited to medically necessary diagnostic, laboratory, radiological and surgical procedures required for treatment of conditions of the feet.

Consultations, routine foot care, preventive or reconstructive procedures and screenings, x-rays, laboratory work or similar services are not covered unless specifically required by the foot condition.

Covered services are limited to those provided by Podiatrist meeting the requirements of 42 CFR 440.60.

Certain services and unusual procedures require prior approval.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments, which are medically necessary to correct or lessen health problems detected or suspected by the screening process, must be provided to individuals under age 21.

Benefit Provided: Home health - intermittent or part time nursing

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 7a from state plan: intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area. Prior authorization is required with the following exceptions:
-Visits within a 60 calendar day period immediately following inpatient discharge from an acute care or rehabilitation hospital.
-The client is eligible for these services under Medicare.

Benefit Provided:

Home health - home health aide by agency

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 7b from state plan: home health aide services provided by a home health agency. Prior authorization is required with the following exceptions:
-Visits within a 60 calendar day period immediately following inpatient discharge from an acute care or rehabilitation hospital
-The client is eligible for these services under Medicare.

Benefit Provided:

Diagnostic services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 13a from state plan.

Alternative Benefit Plan

Benefit Provided:
Hospice services

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Limited to services related to terminal illness.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Item 18 from state plan. Requires notice of election from provider. For individuals whose illness is deemed terminal with a life expectancy of six months or less. Individuals age 19 and 20 may receive concurrent treatment while also receiving hospice services.

Benefit Provided:
Pediatric or family NP services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Item 23 from state plan.

Benefit Provided:
Advance practice nurse services

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 25 from Appendix to Attachment 3.1. Advance practice nurses include: certified registered nurse anesthetist; certified nurse midwife; certified nurse practitioner; and clinical nurse specialist.

Remove

Benefit Provided:

Dental services for individuals younger than 21

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Scope limits are described below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 10 from state plan.

Dental services are categorized below and comport with 42 CFR 440.100.

Procedures covered under each category and prior approval or emergency post approval provisions are specified in the Department's Dental Office Reference Manual or Provider Notices.

Dental Services for individuals younger than age 21:

- Clinical oral examinations
- Radiographs
- Preventive
- Restorative
- Endodontics
- Prosthodontics (Dentures)
- Oral surgery
- Orthodontics
- Adjunctive general services
- Periodontics

All services or treatment that are medically necessary to correct or lessen health problems detected or suspected by the Early and Periodic Screening, Diagnosis and Treatment program will be provided to individuals younger than age 21.

Limitations on dental service for individuals younger than age 21:

- Coverage of orthodontia is limited to case which present a severe handicapping malocclusion or a handicapping dentofacial deformity. All orthodontia requires prior approval.
- Experimental dental services are not covered.
- Dental services performed only for cosmetic reasons are not covered.

Add

Alternative Benefit Plan

☑ Essential Health Benefit 2: Emergency services — Collapse All ☐

Benefit Provided: Emergency hospital services (outpatient hospital)

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 24e from state plan.

Benefit Provided: Other medical care - transportation

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 24a in state plan.

Ambulance Service: Requires prior approval except in case of emergency, or transfer from one hospital to another hospital for admission .

Medicar, service car, taxi, private auto: Requires prior approval .

Other (bus, train, airplane, etc.): Requires prior approval.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments, which are medically necessary to correct or lessen health problems detected or suspected by the screening process, must be provided to individuals under age 21.

Add

Alternative Benefit Plan

■ Essential Health Benefit 3: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient hospital services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 1 from state plan. Certain services require authorization:
-Beginning in February 2014, all elective back and coronary artery bypass grafting surgeries will require prior approval.
-Specific admitting diagnosis codes require concurrent review upon admission.

Benefit Provided: Physician services: inpatient

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Items 5a and 5b from state plan. Note that prior approval is required for surgeries for morbid obesity.

Add

Alternative Benefit Plan

☑ Essential Health Benefit 4: Maternity and newborn care — Collapse All ☐

Benefit Provided: Pregnancy-related and post partum services

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 20a from state plan. Includes pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Benefit Provided: Inpatient hospital services: Maternity

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 1 from state plan.

Benefit Provided: Physician services: Maternity

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Items 5a and 5b from state plan.

Remove

Add

Alternative Benefit Plan

Collapse All ☐

☑ Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Benefit Provided: Clinic services - Community mental health services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services are limited to: assessment; treatment plan development and modification; psychotropic medication monitoring and training; crisis intervention; psychiatric therapy; and day treatment.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Item 9 from state plan.

Benefit Provided: Rehabilitative services - ETOH/substance abuse

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Services are limited to: outpatient services (Level I); intensive outpatient (Level II); day treatment (Level III); medically monitored outpatient detoxification (Level III); psychiatric diagnostic service.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Item 13d from state plan.

Benefit Provided: Inpatient hospital services: MH/SU

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Certain limits apply, see below.

Duration Limit: Certain limits apply, see below.

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 1 from state plan. Inpatient detoxification limited to once every 60 days. Excludes services provided in an institution for mental disease.

Benefit Provided:

Physician services: MH/SU

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Items 5a and 5 b from state plan. Group psychotherapy services rendered by a physician are subject to program integrity controls.

Add

Alternative Benefit Plan

■ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☐ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☐ Other coverage limits		
☐ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Illinois's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs. The Department may require prior authorization for the reimbursement of any covered outpatient drugs

Alternative Benefit Plan

■ Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Skilled nursing facilities for persons age 21+

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 4a from state plan. This entry represents short term nursing facility care for rehabilitation. The same item is captured under "other 1937 covered benefits" for the purposes of long-term custodial care. A preadmission screening assessment is required.

Benefit Provided: Physical therapy - rehabilitation & habilitation

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 11a from state plan.

Services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided by a qualified physical therapist as defined in 42 CFR 440.110(a). Prior approval is required for the provision of services by an independent physical therapist or by a community health agency, unless client is under the age of 21 or eligible for these benefits under Medicare.

All services or treatments, which are medically necessary to correct or lessen health problems detected or suspected by the screening process, must be provided to individuals under age 21.

Benefit Provided: Occupational therapy - rehab & habilitation

Source: State Plan 1905(a)

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 11b from state plan.

Services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided by a qualified occupational therapist as defined in 42 CFR 440.110(b). Prior approval is required for the provision of services by an independent occupational therapist or by a community health agency, unless client is under the age of 21 or eligible for these benefits under Medicare.

All services or treatments, which are medically necessary to correct or lessen health problems detected or suspected by the screening process, must be provided to individuals under age 21.

Benefit Provided:
Speech, hearing & language therapy - rehab & hab

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 11c from state plan.

Services are referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided by a speech pathologist or audiologist as defined 42 CFR 440.110(c). Prior approval is required for the provision of services by an independent speech pathologist or audiologist or by a community health agency, unless client is under the age of 21 or eligible for these benefits under Medicare.

All services or treatments, which are medically necessary to correct or lessen health problems detected or suspected by the screening process, must be provided to individuals under age 21.

Benefit Provided:
Home health - med supplies, equipment, appliances

Source:
State Plan 1905(a)

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Item 7c from state plan. Medical supplies, equipment, and appliances suitable for use in the home. Reimbursement for standard medical equipment/supplies are included in all-inclusive per visit rate. Includes coverage for hearing aids.

Benefit Provided:
Eyeglasses and other optical materials

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1 pair every two years

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Item 12d from state plan. Prior approval is required for the following: Contact lens/lenses and related service; custom-made artificial eye; low vision devices; polycarbonate eyeglass lenses for adults, age 21 and over; eyeglasses fabricated by suppliers other than the Illinois Department of Corrections or a vendor or vendors procured by the Chicago Public Schools (CPS) serving individuals enrolled in a school within the CPS system; service/materials not otherwise identified on the schedule of procedures for optical services and supplies.

Benefit Provided:
Home health - PT/OT/ST by agency or rehab

Source:
State Plan 1905(a)

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 7d from state plan. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Remove

Add

Alternative Benefit Plan

■ Essential Health Benefit 8: Laboratory services

Collapse All ☐

Benefit Provided:

Other laboratory and x-ray services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Radiological and X-ray services are covered when essential for the diagnosis and treatment of disease or injury. Laboratory tests and examinations, which are essential for diagnosis and evaluation of treatment, are covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Item 3 from state plan.

Add

Alternative Benefit Plan

■ Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All ☒

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:	Source:	
	State Plan 1905(a)	Remove

Add

Alternative Benefit Plan

☑ Essential Health Benefit 10: Pediatric services including oral and vision care Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
All EPSDT services are covered for members under the age of 21 years.

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐

Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary care visit to treat an injury or illness.
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Physician services."

Base Benchmark Benefit that was Substituted: Specialist visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Physician services."

Base Benchmark Benefit that was Substituted: Other practitioner visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Advance Practice Nurse Services" and "Pediatric or family nurse practitioners' services."

Base Benchmark Benefit that was Substituted: Outpatient facility fee (e.g., ambulatory surgery)
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Outpatient hospital services."

Base Benchmark Benefit that was Substituted: Outpatient surgery physician/surgical services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Physician services."

Base Benchmark Benefit that was Substituted: Hospice services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Hospice services."

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Infertility treatment

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Substituted with EHB 1 "Dental services."

Base Benchmark Benefit that was Substituted:
Private duty nursing

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Substituted with EHB 1 "Dental services."

Base Benchmark Benefit that was Substituted:
Urgent care centers or facilities

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Outpatient hospital services.""

Base Benchmark Benefit that was Substituted:
Home health care services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Home health - intermittent or part time nursing services" and "Home Health - home health aide by agency" and EHB 7 "Home health - med supplies, equipment, appliances," and Home health - PT/OT/ST by agency or rehab."

Base Benchmark Benefit that was Substituted:
Emergency room services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 2 "Emergency hospital services (outpatient hospital)."

Base Benchmark Benefit that was Substituted:
Emergency transportation/ambulance

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 2 "Other medical care - transportation."

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Inpatient hospital services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 3 "Inpatient hospital services."

Base Benchmark Benefit that was Substituted: Inpatient physician and surgical services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 3 "Physician services."

Base Benchmark Benefit that was Substituted: Bariatric surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 3 "Physician services" and "Inpatient hospital services."

Base Benchmark Benefit that was Substituted: Cosmetic surgery for correction of deformities

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 3 "Physician services" and "Inpatient hospital services," which include reconstructive surgery for accidents and to correct deformities.

Base Benchmark Benefit that was Substituted: Skilled nursing facility

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 7 "Skilled nursing facilities for persons age 21 and older."

Base Benchmark Benefit that was Substituted: Prenatal and post natal care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 4 "Pregnancy-related and post partum services."

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Delivery & inpatient services for maternity care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 4 "Inpatient hospital services" and "Physician services."

Base Benchmark Benefit that was Substituted:
Mental /behavioral health outpatient services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 5 "Clinic services - Community mental health services."

Base Benchmark Benefit that was Substituted:
Mental/behavioral health inpatient services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 5 "Inpatient hospital services" and "Physician services."

Base Benchmark Benefit that was Substituted:
Substance abuse disorder outpatient services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 5 Rehabilitative services - Alcohol (ETOH) and substance abuse services.

Base Benchmark Benefit that was Substituted:
Substance abuse disorder inpatient services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 5"Inpatient hospital services" and "Physician services."

Base Benchmark Benefit that was Substituted:
Chiropractic care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Substituted with EHB 7: Eyeglasses and other optical materials.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Durable medical equipment

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 7 "Home health - med supplies, equipment, and appliances."

Base Benchmark Benefit that was Substituted:
Hearing aids - bone anchored only

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB7 "Home Health - med supplies, equipment, appliances."

Base Benchmark Benefit that was Substituted:
Diagnostic test (x-ray and lab work)

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Diagnostic services" and EHB 8 "other laboratory and x-ray services."

Base Benchmark Benefit that was Substituted:
Imaging

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Diagnostic services" and EHB 8 "other laboratory and x-ray services."

Base Benchmark Benefit that was Substituted:
Routine foot care for individuals with diabetes

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Podiatrists' services."

Base Benchmark Benefit that was Substituted:
Additional surgical opinion

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:
Duplicates EHB 1 "Physician services."

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Human organ transplants

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 3 "Inpatient hospital services" and "Physician services." Base benchmark will provide benefits only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas, or pancreas/kidney human organ or tissue transplants. ABP will provide benefits for bone marrow, stem cell, pediatric small bowel and liver/small bowel, heart, heart/lung, lung (single or double), liver, pancreas, kidney/pancreas and other types of transplant procedures (including those covered by the base benchmark) that a hospital is certified by the Illinois Department of Healthcare and Family Services to perform.

Base Benchmark Benefit that was Substituted:
Cardiac rehabilitation services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted with EHB 7: Eyeglasses and other optical materials.

Base Benchmark Benefit that was Substituted:
Oral surgery/TMJ

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 1 "Physician services" and "Dental services."

Base Benchmark Benefit that was Substituted:
Nutrition

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 7 "Home health - med supplies, equipment, appliances."

Base Benchmark Benefit that was Substituted:
Blood and blood components

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 1 "Outpatient hospital services," EHB 2 "Emergency hospital services," and EHB 3 "Inpatient hospital services."

Base Benchmark Benefit that was Substituted:
Chemotherapy and radiation therapy

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 1 "Outpatient hospital services," EHB 3 "Inpatient hospital services," and EHB 6 "Prescription drugs."

Remove

Base Benchmark Benefit that was Substituted:

Emerg med care for criminal sexual assault/abuse

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 2 "Emergency hospital services (outpatient hospital)."

Base Benchmark Benefit that was Substituted:

End stage renal disease

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates multiple services, including but not limited to: EHB 1 "Outpatient hospital services" and "Physician services"; EHB 3 "Inpatient hospital services" and Physician services: inpatient"; EHB 6 "Prescription drugs"; and EHB 7 "Home health – medical supplies."

Base Benchmark Benefit that was Substituted:

Physical therapy

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 7 "Physical therapy - rehabilitation and habilitation."

Base Benchmark Benefit that was Substituted:

Occupational therapy

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 7 "Occupational therapy - rehabilitation and habilitation."

Base Benchmark Benefit that was Substituted:

Speech therapy

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 7 "Speech, hearing and language therapy - rehabilitation and habilitation."

Base Benchmark Benefit that was Substituted:

Detoxification

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 5 "Rehabilitative services - ETOH and substance abuse services."

Remove

Base Benchmark Benefit that was Substituted:

Assistant surgeon according to Medicare guidelines

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 3 "Hospitalization (inpatient hospital)."

Base Benchmark Benefit that was Substituted:

Allergy testing

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 1 "Diagnostic services."

Base Benchmark Benefit that was Substituted:

Generic drugs

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 6 "Prescription drugs."

Base Benchmark Benefit that was Substituted:

Preferred brand drugs

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 6 "Prescription drugs."

Base Benchmark Benefit that was Substituted:

Non-preferred brand drugs

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 6 "Prescription drugs."

Base Benchmark Benefit that was Substituted:

Specialty drugs

Source:
Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 6 "Prescription drugs."

Remove

Base Benchmark Benefit that was Substituted:

Habilitation services for children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 10 "Medicaid state plan EPSDT benefits."

Base Benchmark Benefit that was Substituted:

Autism spectrum disorders

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 10 "Medicaid state plan EPSDT benefits."

Base Benchmark Benefit that was Substituted:

Outpatient contraceptive services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplicates EHB 1 "Family planning services and supplies."

Base Benchmark Benefit that was Substituted:

Dental accident care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted with EHB 1 "Dental services."

Base Benchmark Benefit that was Substituted:

Naprapathic services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted with EHB 7: Eyeglasses and other optical materials.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Non-emergency care when traveling outside U.S.

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Medicaid regulations do not allow Illinois to make payments to providers outside the US.

Add

Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided:
Skilled nursing facility for persons age 21+

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Item 4a from state plan. This entry represents long term custodial care. Same item is noted under EHB 7 - Rehabilitative services. A preadmission screening assessment is required and individuals must meet an institutional level of care.

Other 1937 Benefit Provided:
Intermediate care facility services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Item 15a from state plan. Excludes services in an institution for mental disease. A screening assessment is required prior to admission.

Other 1937 Benefit Provided:
Services provided in a public institution for MR

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other:

Item 15b from state plan. A screening assessment is required prior to admission.

Remove

Other 1937 Benefit Provided:

Case management services - target group A

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Yes, see description below.

Other:

Item 19 from state plan. No authorization is required. Case management services for individuals in the community who are receiving mental health services under the rehabilitative or clinic options, including: assessment; planning; advocacy; linkage; monitoring; problem-solving assistance, interagency service coordination, and crisis response management.

Other 1937 Benefit Provided:

Case management services - target group D

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

60 days from initial assessment in ED

Scope Limit:

Yes, see description below.

Other:

Item 19 under state plan. Case management services for persons between 21 and 65 years of age with chronic mental illness. Services are also targeted geographically. Eligibility and services are defined in Illinois Medicaid State Plan, Supplement to Attachment 3.1-A, Page 7 and following.

Other 1937 Benefit Provided:

Rural health clinic

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 encounter of each type per day

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

Item 2b from state plan. No authorization is required. Limited to 1 medical encounter, 1 dental encounter & 1 behavioral health encounter per day.

Other 1937 Benefit Provided:

Federally qualified health center

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 encounter of each type per day

Duration Limit:

None

Scope Limit:

None

Other:

Item 2c from state plan. No authorization is required. Limited to 1 medical encounter, 1 dental encounter & 1 behavioral health encounter per day.

Other 1937 Benefit Provided:

Medical conditions that complicate pregnancy

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Item 20b from state plan. No authorization is required. Covers services for any other medical conditions that may complicate pregnancy.

Other 1937 Benefit Provided:

Free-standing birth center services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other:
No authorization is required.

Other 1937 Benefit Provided:
Tobacco cessation for pregnant women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
See below.

Duration Limit:
See below.

Scope Limit:
See below.

Other:
No authorization is required. Includes four (4) individual face-to-face counseling sessions per quit attempt, with a maximum of three (3) quit attempts per calendar year.

Other 1937 Benefit Provided:
Nurse-midwife services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Item 17 from state plan.

Other 1937 Benefit Provided:
Prosthetic devices

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Item 12c from state plan. Prior approval for purchase, repair and replacement is required (unless the recipient is eligible for Medicare and the item is covered under the Medicare Program); or
-the cost of repairs does not exceed 75% of the purchase price, or
-the item is being loaned while the recipient's own item is being repaired or replaced, or
items are replaced within 24 months of the purchase date and all of the following conditions are met:
--the item is not under warranty
--the item was not faulty at the time of purchase
--the original purchase was made by the Department for the same recipient or for whom the replacement is needed
--the original item is either not repairable or the cost of repairs is more than or equal to the replacement; and
--the replacement item is new and of equal value to the original item.

Other 1937 Benefit Provided:
Mental health rehab services - assessment

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Item 13d from state plan. Authorization is not required.

Other 1937 Benefit Provided:
Mental health rehab - treatment plan development

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

Item 13d from state plan. Authorization is not required.

Other 1937 Benefit Provided:

Mental health rehab - psychiatric treatment

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See below

Other:

Item 13d from state plan. Authorization is not required. Includes psychotherapy/counseling and psychotropic medication management.

Other 1937 Benefit Provided:

Mental health rehab services- crisis intervention

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Item 13d from state plan. Authorization is not required.

Other 1937 Benefit Provided:

Mental health rehab - psychosocial rehabilitation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other:
Item 13d from state plan. Authorization is not required.

Other 1937 Benefit Provided:
Mental health rehab - community support

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Item 13d from state plan. Authorization is not required.

Other 1937 Benefit Provided:
Mental health rehab-assertive community treatment

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Item 13d from state plan. Authorization is not required.

Other 1937 Benefit Provided:
Mental health rehab - comprehensive rehab services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See below

Other:
An array of mental health rehabilitation services included in ABP5 "Other Covered Benefits that are not Essential Health Benefits" except assertive community treatment provided on an encounter basis to an eligible enrollee under 21 who is in a state-approved living arrangement that is not an IMD; does not cover room and board.

Other 1937 Benefit Provided:
Dental services for individuals age 21 and older

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Scope limits described below

Other:
Dental services for individuals age 21 and older:
● Extractions medically necessary to treat emergency dental conditions of pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Covered services related to the extraction include: initial oral exams, radiographs, sedation and, if necessary oral surgery.
● Dental services that are medically necessary as a prerequisite for necessary medical care.
● Initial oral examinations
● Radiographs
● Oral Surgery
● Restorative
● Anterior Endodontics
● Prosthodontics (Dentures)
● Denture relining or repair
● Adjunctive general services

Limitations on dental services for individuals 21 and older:
● Full mouth series of x-rays are covered only once every three years.
● Polycarbonate crowns are covered; acrylic are not.
● Complete dentures (if necessary) are allowable only once every five years.
● Bridgework is allowable only once in five years.
● Coverage of root canals and apicoectomy procedures is covered for anterior teeth, bicupsids and first molars only.

- Experimental dental services are not covered.
- Dental services performed only for cosmetic reasons are not covered.

Remove

Add

Alternative Benefit Plan

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 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.

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☒ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The State of Illinois requires most ACA adults to enroll in some form of care coordination. Options include health plans (Managed Care Organizations and Managed Care Community Networks) and a number of Primary Care Case Management (PCCM) models, including Coordinating Entities that provide extensive care coordination services (Accountable Care Entities, Care Coordination Entities, and Medical Home Network), as well as a more traditional PCCM model.

In five mandatory regions of the state (Central Illinois, Greater Chicago, Metro East, Quad Cities, and Rockford), ACA Adults must enroll in a health plan or in a Coordinating Entity that offers extensive care coordination. In counties outside the mandatory regions, ACA Adults must enroll in a more traditional PCCM; or, in certain counties, enrollees may choose to join a voluntary managed care organization.

Enrollees who do not make a care coordination selection within the 60 day enrollment period are auto-assigned. All models of service delivery for ACA adults are described in Illinois' State Medicaid Plan and related State Plan Amendments (SPAs).

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. No

☑ The Alternative Benefit Plan will be provided through a managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

Alternative Benefit Plan

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

- (•) Competitive procurement method (RFP, RFA).
- ( ) Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. No

MCO service delivery is provided on less than a statewide basis. Yes

The limited geographic area where this service delivery system is available is as follows:

- (•) MCO service delivery is available only in designated counties.
- ( ) MCO service delivery is available only in designated regions.
- ( ) MCO service delivery is available only in designated cities and municipalities.
- ( ) MCO service delivery is available in some other geographic area (geographic area must not be smaller than a zip code).

Specify counties:

Health plans that receive mandatory enrollment are available in the following counties: Boone, Champaign, Christian, Clinton, Cook, DeWitt, DuPage, Ford, Henry, Kane, Kankakee, Knox, Lake, Logan, Macon, Madison, McHenry, McLean, Menard, Mercer, Peoria, Piatt, Rock Island, Sangamon, St. Clair, Stark, Tazewell, Vermilion, Will, and Winnebago.

Voluntary MCOs are available in the following counties: Adams, Brown, DeKalb, Henderson, Jackson, Lee, Livingston, Perry, Pike, Randolph, Scott, Warren, Washington, Williamson, and Woodford.

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

- [x] Individuals with other medical insurance.
- [ ] Individuals eligible for less than three months.
- [x] Individuals in a retroactive period of Medicaid eligibility.
- [x] Other:

Describe:

a) individuals that are dually eligible for both Medicare and Medicaid; b) individuals who are eligible only after a "spend-down" of income or assets; c) children of those individuals whose care is subsidized by the Department of Children and Family Services and individuals for whom some of all of their care is the responsibility of the Department of Corrections or the Department of Juvenile Justice; d) inmates of a public institution; e) individuals enrolled in a presumptive eligibility program; f) individuals enrolled in limited benefit programs; and g) populations already managed.

Alternative Benefit Plan

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

- (•) Mandatory participation.
- ( ) Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

In mandatory regions of the state, members are given 60 days to select a health plan or one of the PCCM models that provides extensive care coordination. After 60 days, members are auto-assigned.

In counties outside of the mandatory regions where only traditional PCCM is available, members are given 60 days to select a PCCM. After 60 days, members are auto-assigned to a PCCM.

In counties outside of the mandatory regions where voluntary managed care organizations are available, members are given 60 days to select a PPCM or a voluntary MCO. Enrollment in the voluntary MCO is through affirmative selection. Therefore, if no choice is made during the 60 day enrollment period, they are auto-assigned to a PCCM.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

Additional detail about Illinois' MCO implementation for ACA Adults is available in SPA 14-0038.

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. No

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

PCCM service delivery is provided on less than a statewide basis. Yes

The limited geographic area where this service delivery system is available is as follows:

- (•) PCCM service delivery is available only in designated counties.
- ( ) PCCM service delivery is available only in designated regions.
- ( ) PCCM service delivery is available only in designated cities and municipalities.
- ( ) PCCM service delivery is available in some other geographic area (geographic area must not be smaller than a zip code).

Specify counties:

Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, Champaign, Christian, Clark, Clay, Clinton, Coles, Cook, Crawford, Cumberland, DeKalb, DeWitt, Douglas, DuPage, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, JoDaviess, Johnson, Kane, Kankakee, Kendall, Knox, Lake, LaSalle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Marion, Marshall, Mason, Massac, McDonough, McHenry, McLean, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, Saline, Sangamon, Schuyler, Scott, Shelby, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Warren, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago, and Woodford

PCCM Payments

Specify how payment for services is handled:

○ Per member/per month case management fee paid to PCCM provider.

◉ Other:

Describe:

Payment to providers for services is made on a fee for service basis. Per member/per month care management fees are paid to the entity responsible for care coordination. Illinois has implemented four PCCM models, described below.

Additional Information: PCCM (Optional)

Provide any additional details regarding this service delivery system (optional):

Two categories of primary care case management are available to ACA Adults in Illinois.

1. Coordinating Entities provide extensive care coordination services. Illinois has implemented three models:

a. A Care Coordination Entity (CCE) is a collaboration of providers and community agencies, governed by a lead entity that receives a care coordination payment in order to provide care coordination services for its Enrollees. The CCE maintains networks of providers and community partners who deliver coordinated quality care across provider and community settings to Enrollees, with a particular emphasis on managing transitions between levels of care and coordination between services for physical health, mental health, and substance abuse.

b. An Accountable Care Entity (ACE) is an organization comprised of and governed by its participating providers, with a legally responsible lead entity, that receives a care coordination payment to coordinate the care of its enrollees, and is accountable for the quality, cost, and overall care of its Enrollees. The ACE demonstrates an integrated delivery system, appropriately shares clinical information in a timely manner, and designs and implements a model of care and financial management structure that promotes provider accountability, quality improvement, and improved health outcomes.

c. Medical Home Network (MHN) is an integrated delivery network that receives a care coordination payment to coordinate the care of its enrollees and virtually links hospitals and primary care sites, know as medical homes, to facilitate communication and ensure care continuity between participating institutions through real-time activity alerts and access to pertinent information at the point of care.

2. Illinois Health Connect (IHC) is a traditional PCCM program in which primary care providers are paid monthly care management fees. IHC is based on the American Academy of Pediatrics' initiative to create medical homes to make sure that primary and preventive healthcare is provided in the most appropriate setting. Enrollment in IHC is mandatory for ACA Adults who live outside of the five regions of the state where more intensive care coordination is available (Rockford, Central Illinois, Metro East, Quad Cities, and Cook and Collar Counties) and who are not otherwise exempt from mandatory enrollment.

Additional detail about Illinois' PCCM implementation for ACA Adults is available in SPA 14-0021.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The fee-for-service delivery system for the Alternative Benefit Plan is the same system described in Illinois' approved Medicaid State Plan. While most ACA adults will be enrolled on a mandatory basis into one of the service delivery systems specified above,

the traditional state-managed fee-for-service system will persist for those ACA adults who are exempt from mandatory enrollment.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Additional detail about the fee-for-service system for ACA Adults is contained in Illinois' State Medicaid Plan.

PRA Disclosure Statement

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

Any individual who qualifies for Medicaid and has access to employer sponsored insurance may apply to Illinois' Health Insurance Premium Program. The amount of premium assistance for state fiscal year 2013 (July 1, 2012-June 30, 2013) was $577,810. Illinois' Medicaid state plan requires a cost effectiveness calculation of at least 2.5/1.

The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. **No**

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

V.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

V.20131219

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

V.20130917

ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

PUBLIC NOTICE OF ALTERNATIVE BENEFIT PLAN (ABP) FOR NEWLY ELIGIBLE ACA ADULTS

The Affordable Care Act (ACA) requires states to provide adults who are covered via the Medicaid expansion with an Alternative Benefit Plan (ABP). An ABP is implemented through a state plan amendment and ABP services are a specific set of services available to a targeted group of individuals – in this case, the ACA adult eligibility group.

HFS invited public input on the ABP in the fall of 2012. (At that time, ABPs were referred to as "benchmark Medicaid plans".) Broadly speaking, most respondents indicated that Illinois' ABP should include the same services available to Medicaid clients in Illinois' state plan today, with the possible exception of Long Term Supports and Services (LTSS) which are more oriented to Seniors and Persons with Disabilities (the SPD population).

The federal government did not release the final administrative rules on the ABP until July 2013. It appears the goal was to create as much continuity as possible with the Essential Health Benefits (EHBs) offered by commercial health plans through the Health Insurance Marketplace. Among other issues, emphasis was placed on certain "exempt groups", including the "medically frail".

HFS is seeking public input as we finalize an ABP for Illinois, with consideration of issues outlined below.

Key Objectives for the Illinois Alternative Benefit Plan (ABP)

- Cover the services needed by ACA Adults.
- Comply with requirements to secure federal reimbursement at 100% FMAP.
- Support clients in the community and enhance state efforts to rebalance the long term care service system.

HFS Recommendations

1. **Illinois' ABP should be based on its existing Medicaid benefit package to promote equity and coverage of necessary services.** The Illinois Department of Healthcare and Family Services (HFS) recommends that the ABP be comprised of all Illinois Medicaid state plan services, i.e., be in full alignment with Illinois' current state plan. This approach ensures that ACA Adults receive the same services as current Medicaid clients. Illinois' state plan services are designed with a low-income population in mind, and therefore are well suited to the needs of ACA Adults.
2. **Illinois should cover habilitative services to meet federal requirements to cover all essential health benefits.** Habilitative services allow individuals to maintain or attain certain functioning levels and are distinct from rehabilitative services, which focus on restoring individuals to functioning levels lost due to injury, illness, etc. The ABP should include habilitative services that mimic the rehabilitative services

currently covered in the state plan, specifically: physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders. Habilitative services should be added to the state plan so that all adult Medicaid clients will have access to them and the Medicaid benefit packages continue to be in full alignment.

3. **Long Term Supports and Services (LTSS).** ACA Adults who apply for institutional LTSS should undergo the same assessment as the SPD population. The ACA Adults and the SPD population will continue to have different eligibility requirements consistent with federal requirements. Consistent with Governor Quinn's commitment to community integration, community-based LTSS should also be available to ACA Adults.
4. **Copays.** Copays shall be fully aligned between the ABP and the current state plan.
5. **In summary**, the ABP for ACA adults will include:
    - Essential Health Benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services; laboratory services; and preventive and wellness services
    - Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT) for 19 and 20 year olds
    - Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services
    - Non-emergency transportation
    - Family planning services and supplies

Considerations

- Our existing Medicaid package is designed with Illinois' low-income population in mind, and therefore is well-suited to the needs of ACA Adults.
- Most states are pursuing full alignment.
- Full alignment is easier and more efficient for clients, providers and the state to understand and administer. Because the ABP will be fully aligned with current state plan services, all ACA Adults, including those who fall in the ABP exempt groups (e.g. "medically frail"), will have access to the same state plan services and the state will not need to develop a process to identify ABP exempt groups.
- In order to include ACA Adults in the same assessment process as the SPD population for institutional LTSS, the state will have to refine its current assessment process.
- In the future, all managed care entities in Illinois Medicaid will be required to cover the costs of LTSS and will provide a powerful mechanism for ensuring that the Medicaid population is receiving the most appropriate level of care. (This will also require the State to make the specific actuarial adjustments to insure these services are appropriately reflected in capitation rates paid to the managed care entities.)

Next Steps

- Launch a process by which stakeholders will review and comment on the HFS recommendations, and help inform the development of policies to ensure appropriate access to both community-based and institutional LTSS.
- Proceed with actuarial analysis to demonstrate that the ABP covers all essential health benefits (EHBs) in accordance with federal requirements. Milliman, HFS' actuarial firm, has begun working with HFS on this analysis.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PUBLIC INFORMATION

1. Statute requiring agency to publish information concerning proposed changes in methods and standards for establishing medical assistance payment rates for medical services in the Illinois Register: 5 ILCS 100/5-70(c)

2. Summary of information: The Affordable Care Act (ACA) requires states to provide adults who are covered via the Medicaid expansion with an Alternative Benefit Plan (ABP). An ABP is implemented through a state plan amendment and ABP services are a specific set of services available to a targeted group of individuals – in this case, the ACA adult eligibility group.

HFS invited public input on the ABP in the fall of 2012. (At that time, ABPs were referred to as "benchmark Medicaid plans".) Broadly speaking, most respondents indicated that Illinois' ABP should include the same services available to Medicaid clients in Illinois' state plan today, with the possible exception of Long Term Supports and Services (LTSS) which are more oriented to Seniors and Persons with Disabilities (the SPD population).

The federal government did not release the final administrative rules on the ABP until July 2013. It appears the goal was to create as much continuity as possible with the Essential Health Benefits (EHBs) offered by commercial health plans through the Health Insurance Marketplace. Among other issues, emphasis was placed on certain "exempt groups", including the "medically frail".

HFS is seeking public input as we finalize an ABP for Illinois, with consideration of issues outlined below.

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services as current Medicaid clients. Illinois' state plan services are designed with a low-income population in mind, and therefore are well suited to the needs of ACA Adults.

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4) **Copays.** Copays shall be fully aligned between the ABP and the current state plan.

5) **In summary**, the ABP for ACA adults will include:

- Essential Health Benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services; laboratory services; and preventive and wellness services
- Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT) for 19 and 20 year olds
- Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services
- Non-emergency transportation
- Family planning services and supplies

Considerations

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PUBLIC INFORMATION

- Our existing Medicaid package is designed with Illinois' low-income population in mind, and therefore is well-suited to the needs of ACA Adults.
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Next Steps

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- Proceed with actuarial analysis to demonstrate that the ABP covers all essential health benefits (EHBs) in accordance with federal requirements. Milliman, HFS' actuarial firm, has begun working with HFS on this analysis.

3. Name and address of person to contact concerning this information:

Bureau of Program and Reimbursement Analysis
Division of Medical Programs
Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0001
E-mail address: bpra@illinois.gov

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PUBLIC INFORMATION

Interested persons may review these proposed changes on the HFS Public Involvement Web page <http://www2.illinois.gov/hfs/PublicInvolvement/>. Local access to the Internet is available through any local public library. In addition, this material may be viewed at the DHS local offices (except in Cook County). In Cook County, the changes may be reviewed at the Office of the Director, Illinois Department of Healthcare and Family Services, 401 South Clinton Street, Chicago, Illinois. The changes may be reviewed at all offices Monday through Friday from 8:30 a.m. until 5:00 p.m. This notice is being provided in accordance with federal requirements found at 42 *CFR* 447.205.

[HOC_NAME]
[ADDRESS_LINE2]
[ADDRESS_LINE1]
[CITY], [STATE] [ZIPCODE]-[ZIP4]

[LETTER_DATE]

Dear [HOC_NAME]:

Managed Care is expanding in Illinois!

Now you have new health plans to choose from. Please read everything that came with this letter to make the best choice for you.

You must enroll in a health plan.
To enroll (become a member), you must choose a health plan and a primary care provider (PCP). Your PCP is the doctor or clinic you go to when you are sick or need a checkup. Your health plan is the group of doctors, hospitals, and other providers who work together to give you the healthcare you need.

Even if you already have a health plan, it's important that you learn about your new healthcare choices.

You must choose by [DATE].
Please choose a health plan and PCP for each person listed here:

[HOC_NAME]	Date of birth: **[HOC_DOB]**	ID #: **[HOC_RIN]**
[ENROLLEE2]	Date of birth: **[EN2_DOB]**	ID #: **[EN2_RIN]**

The health plans you can choose from are:

- [Harmony Health Plan]
- [Meridian Health Plan]
- [Molina Healthcare]

If you do not choose by [DATE], we will choose for you.
It is better if you choose because you know your healthcare needs best. For help choosing a health plan and PCP, read ***Tips to Help You Choose*** and ***Your Health Plan Choices*** that came with this letter.

More on the back »

Questions? Visit **www.EnrollHFS.Illinois.gov** or call **1-877-912-8880** (TTY: 1-866-565-8576). The call is free!
You can get this information in other languages or formats, such as large print or audio. Tenemos información en español. ¡Servicio de intérpretes gratis! Llame al 1-877-912-8880.

There are two ways to enroll:

- Go to **www.EnrollHFS.Illinois.gov** and click "Enroll."
- Call us at **1-877-912-8880** (TTY: 1-866-565-8576). The call is free.

After you enroll, the health plan will send you a Welcome Packet in the mail.

If you want to change your health plan:
You can change your health plan anytime in the first 90 days. After that, you cannot change health plans for one year. Once each year, you can change health plans during the time called "open enrollment."

Thank you,
Illinois Client Enrollment Services

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Illinois Client Enrollment Services

Tips to Help You Choose

Need help choosing a health plan or PCP?

You must choose one of these health plans: [Harmony Health Plan], [Meridian Health Plan], and [Molina Healthcare], and choose a doctor or clinic to be your Primary Care Provider (PCP).

TIP 1

Think about your answers to these questions:

- Do you know which doctor or clinic you would like to see for your healthcare? Call the doctor or clinic to find out which health plans they have joined.
- Does the health plan your PCP has joined have the hospitals and specialists you use?
- What extra services does the health plan have?
- Do you need help finding a doctor or clinic?
- Do you need a doctor who speaks a certain language?
- Do you want to choose the same health plan and PCP for everyone in your family? You can choose a different health plan and PCP for each person.

TIP 2

- Read ***Your Health Plan Choices*** to learn about the services you can get from each plan.
- Read ***How to Enroll in a Health Plan*** to learn how to enroll in (join) the health plan you choose.
- Before starting the enrollment process, fill in the blanks on the back of this form so you'll be ready.

TIP 3

Illinois Client Enrollment Services can help you find a health plan and PCP, or enroll. There are two ways to get help or enroll.

- **Go to www.EnrollHFS.Illinois.gov.**
  - To see what extra services the health plans have, click **"Compare Plans"**
  - To find a doctor or clinic near you, click **"Find Providers"**
  - To enroll, follow the ***Step-By-Step Help to Enroll Online*** on the back of this page.
- **Call Illinois Client Enrollment Services at 1-877-912-8880 (TTY 1-866-565-8576).**
  - The call is free.
  - Call Monday to Friday from 8 a.m. to 7 p.m. and Saturday from 9 a.m. to 3 p.m.

Questions? Visit **www.EnrollHFS.Illinois.gov** or call **1-877-912-8880** (TTY: 1-866-565-8576). The call is free! You can get this information in other languages or formats, such as large print or audio. Tenemos información en español. ¡Servicio de intérpretes gratis! Llame al 1-877-912-8880.

Step-By-Step Help To Enroll Online

1. Go to **www.enrollhfs.illinois.gov**
2. To find a doctor, click **"Find Providers"**
3. To compare the services and extra benefits of the health plans, click **"Compare Plans"**
4. Before starting the enrollment process, fill in the blanks below so you'll be ready:

Doctor or Clinic Name	Doctor or Clinic Phone Number
Doctor or Clinic Address	
Your Name *(as it appears on your HFS medical card)*	Your Recipient ID Number *(9 digits)*
Your Social Security number	Your Date of Birth

5. To Enroll, go back to the home page and click **"Enroll"**
6. Click on **"Login Now"** and scroll down to **"Case Members Start Here"**
7. Type in your *first* name exactly how it appears on your medical card and Tab
8. Type in your *last* name exactly how it appears on your medical card and Tab
9. Complete at least two of the three remaining fields, date of birth, recipient ID number, or last 4 digits of your social security number and click **"Login"**
10. Click on the box next to the name of the case member you would like to enroll. You can enroll one case member at a time. Or if you are enrolling all case members with the same health plan and PCP, you can select all case members. Click on **"Choose a PCP"**.
11. If you know the doctor's name or phone number, click **"Yes"**. If not, click **"No"**.
12. If "Yes", type in the doctor's last name. Scroll down and fill in one of the three location fields and click **"Search"**. [If the PCP you want is a clinic, click **"No"** because there is a place for clinic or group practice name on the next screen. If you enter a zip code, make sure you specify a distance also.]
13. If "No", fill in as many of the other search criteria as possible. [To search by group practice/clinic name, scroll all the way down to the last question and enter clinic name.]
14. When the provider list comes up, and you see the doctor or clinic you want, click on **"Choose this PCP"**.
15. All the health plans you can pick from will appear on the screen. The health plans your PCP works with will have a **"Choose Plan"** button on the right side. After reviewing the services and extra benefits of the plans and picking one, click on **"Choose Plan"**.
16. You will then be asked to **"Confirm"** or **"Make Changes"** to your enrollment.
17. There are health assessment questions that you can answer that will help your PCP and health plan coordinate your care.

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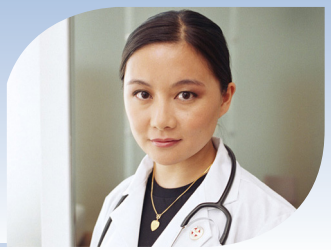

Frequently Asked Questions

Can I keep my doctor as my Primary Care Provider (PCP)? Yes, if your doctor is in the health plan you choose.

Can I stay with Illinois Health Connect? No. Illinois Health Connect is no longer a choice. You must choose a different plan.

Where can I see all of my plan options? Read *Your Health Plan Choices* that came with this brochure. Or go to www.EnrollHFS.Illinois.gov and click "Compare Plans."

What happens if I don't choose a health plan? If you don't choose a health plan, we will choose a plan and a PCP for you.

Will I lose any services? No. You will not lose any services. Some health plans have extra services.

Will I have a co-pay? If you have a co-pay now, you may still have one. Some health plans have no co-pays.

Can I change my health plan? Yes. You can change your health plan anytime in the first 90 days. After that, you cannot change health plans for one year. Once each year, you can change health plans during the time called "open enrollment."

Can I change my PCP? Yes. You can change your PCP once a month. To change your PCP, call your health plan.

IFN No. IL-14-0041
Illinois

Who must enroll in a health plan? Most people with an HFS Medical card must enroll in a health plan. If you received this brochure in the mail, you must enroll.

Who does not have to enroll? These are some reasons why you would not have to enroll in a health plan:

- You are enrolled in the Spenddown Program
- You get temporary medical benefits
- You are getting care in the Illinois Breast and Cervical Cancer Program
- You already have private insurance that covers hospital and doctor visits

Questions?

Go to **www.EnrollHFS.Illinois.gov**

Or call **1-877-912-8880** (TTY 1-866-565-8576)
Monday to Friday from 8 a.m. to 7 p.m.
Saturday from 9 a.m. to 3 p.m. The call is free.

You can get this information in other languages or formats, such as large print or audio.

Tenemos información en español. ¡Servicio de intérpretes gratis! Llame al 1-877-912-8880.

Approval Date: March 12, 2015

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ILLINOIS DEPARTMENT OF Healthcare and Family Services

Illinois Client Enrollment Services

How to Enroll in a Health Plan

Managed Care is Expanding in Illinois!

Effective Date: July 1, 2014

Managed Care is Expanding in Illinois!

Now you have new health plans to choose from. All plans have the same health services that you get now, plus extra benefits.

Even if you already have a health plan, it's important that you learn about your new healthcare choices.

With Managed Care, you and your family get the healthcare you need.

When you enroll, you will choose a primary care provider (PCP) and one health plan to cover all your healthcare.

Your PCP will:

- Take care of you when you are sick or need medical care
- Give your children regular checkups and immunizations (shots)
- Help you manage conditions like diabetes, high blood pressure, and asthma
- Send you to specialists and other providers when you need them (give you a referral)
- Answer your questions about healthcare
- Give you information you need to stay healthy

TN No: IL-14-0041
Illinois

You must enroll in a health plan.

To enroll (become a member), you must choose a health plan and a primary care provider (PCP). Your PCP is the doctor or clinic you go to when you are sick or need a checkup. Your health plan is the group of doctors, hospitals, and other providers who work together to give you the healthcare you need.

Which health plan should you choose?

You can choose the same plan for everyone in your family. Or you can choose different plans.

To help you choose, think about your answers to these questions:

- Do you want to keep your doctor or clinic, or do you want a new doctor or clinic?
- Does the health plan have the doctors, hospitals, and specialists you use?
- What extra services does the health plan have?
- How far are you willing to travel to see a doctor?
- Do you need a doctor that speaks a certain language?

Approval Date: March 12, 2015

The health plans you can choose from are:

- Harmony Health Plan
- Meridian Health Plan
- Molina Healthcare

There are two ways to enroll:

1. **Online:** Go to www.EnrollHFS.Illinois.gov and click "Enroll."
2. **Phone:** Call 1-877-912-8880 (TTY 1-866-565-8576). The call is free.

Questions?

Visit **www.EnrollHFS.Illinois.gov** or call **1-877-912-8880** (TTY: 1-866-565-8576). Monday to Friday from 8 a.m. to 7 p.m. Saturday from 9 a.m. to 3 p.m. The call is free!

You can get this information in other languages or formats, such as large print or audio.

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Effective Date: July 1, 2014

ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Procedures for Enrollment of Medicaid Clients into Care Coordination

Webcast

June 30, 2014

Illinois Medicaid Vision

- Our vision is aligned with national healthcare reform and state Medicaid reform
- We are working to fulfill the vision of the "Triple Aim"
  - Improving the quality of care
  - Improving the health of populations, and
  - Reducing the growth in health care costs
- 2011 Medicaid reform law (P.A. 96-1501) mandates 50% of clients to be enrolled in "care coordination" by 1/1/15
- Even without state mandate, we believe that care coordination is needed to achieve the Triple Aim
- Care coordination requires the redesign of the Medicaid Program into networks and Health Plans

Our Unique Structure: Models of Managed Care Entities

- Different Health Plans for different Medicaid populations
  - Seniors and Persons with Disabilities (SPD) – Medicaid-only & Medicare/Medicaid (duals)
  - Children, Parents/Caretaker Relatives, Pregnant Women – called "Family Health Plans" (FHP)
  - Children with Special Needs (CSN)
  - Newly Eligible Adults under the Affordable Care Act – called "ACA Adults" (ACA)
- 4 different models of Managed Care Entities offering Health Plans
  - Managed Care Organizations (MCO)
  - Managed Care Community Networks (MCCN)
  - Care Coordination Entities (CCE)
  - Accountable Care Entities (ACE)

Care Coordination in Mandatory Regions

- Clients are in process of enrolling or being enrolled in Health Plans in 5 mandatory regions
  - Chicago region – 6 counties
  - Rockford region – 3 counties
  - Central Illinois region - 15 counties
  - Quad Cities region – 3 counties
  - Metro East region – 3 counties
- Clients in rural counties will continue to be in IL Health Connect (fee-for-service) for a while
- About 2 million Medicaid clients will be in Health Plans by mid-2015

Clients Must Choose a Health Plan

- Initial enrollment packet mailed to clients includes a letter and brochure, “Your Health Plan Choices,” for area where client resides
- Goal is to have clients select a Health Plan voluntarily
- Clients may change their Health Plan once during initial 90 days of enrollment
- After 90 days they are “locked in,” or required to remain with Health Plan for one year (if they remain eligible for Medicaid)
- Clients may change a Health Plan any time, if they have cause
- At end of one-year lock-in period, clients have option to change Health Plans or stay with their current plan

Enrollment Process for Clients

- Two ways to enroll:
  - by going online at www.enrollHFS.Illinois.gov or
  - by calling Client Enrollment Services (CES) at 1-877-912-8880
- When enrolling by phone client talks to Client Enrollment Broker (CEB), a neutral party not part of any Health Plan and ready to educate and assist clients to make a choice
- CEBs will be available from 8 a.m. to 7 p.m. Monday through Friday, and from 9 a.m. to 3 p.m. Saturday

What If Client Doesn't Choose a Health Plan?

- Clients have 60 days during voluntary enrollment period to pick a Health Plan with a Primary Care Provider (PCP)
- If client does not select a Health Plan within the first 30 days of the voluntary enrollment period, CES will mail a second enrollment packet to the client
  - Packet identifies the Health Plan (with PCP) to which client will be assigned by day 60 of voluntary enrollment period
- If client does not select a Health Plan during 60-day voluntary enrollment period, client will be automatically enrolled (or "auto-enrolled") in a Health Plan

How Will The Auto-Enrollment Process Work?

- The key criterion for auto-enrollment is the Primary Care Provider (PCP) to assure continuity of care
  - Under Illinois Health Connect, most children and adults in Illinois Medicaid have a Primary Care Provider (PCP)
  - Auto-enrollment process will assign client to the same PCP, as long as PCP is in network of a Health Plan serving client's area
- If PCP is in more than one Health Plan, the auto-enrollment process will make every effort to balance enrollments among Health Plans
- For newly enrolling Medicaid clients with no PCP, the auto-enrollment process will select a Health Plan with an available PCP serving the area where client resides

Enrollment Mailing Schedule

- Enrollment mailing schedule called "Managed Care Expansion Mail Schedule" shows mailing by week and by county
  - Is posted on HFS Website – and will be updated as necessary
- Client does not have to wait to receive enrollment packet – may call CEB, but only at the beginning of the week for mailing into his/her county
- By now, almost all Seniors and Persons with Disabilities are enrolled
- All other populations in mandatory managed care regions – children and adults in Family Health Plans, ACA Adults (with the exception of ACA Adults in CountyCare) and Children with Special Needs – will receive the initial enrollment packet by the end of 2014; some clients will be in auto-enrollment phase at 60th day if they have not selected a Health Plan
- ACA Adults who enrolled in CountyCare in 2013 and 2014 will not receive their enrollment packet to stay in CountyCare, or select another Health Plan, until 2015

Medicaid is Changing for Providers!

- Medicaid clients will no longer be able to go “anywhere that accepts Medicaid”
- Please take steps to keep Medicaid clients under your care
  - Important to understand that your patients are or will be enrolled with a Health Plan if they live in one of 5 mandatory managed care regions
  - Join network of one or more of the Health Plans
  - Become familiar with Health Plans with which you have a contract – understand which hospitals and specialists are associated with each Health Plan and what new services may be offered
- Your clients will receive enrollment packet and may ask your advice on which Health Plan to select – follow the guidelines

Must Follow Guidelines for Client Enrollment Education

- Managed care entities offering Health Plans – and the PCPs and other providers in their network – may reach out to their members or patients
- But outreach and education must follow limits established by federal law and "HFS Health Plan Outreach Guidelines" posted on HFS Website
- HFS must review and approve all materials related to or containing information regarding Health Plan choice before they may be used for education, outreach or marketing purposes. Send materials to Bureau of Managed Care at HFS.hlthplanoutreach@illinois.gov

No Cold Call Outreach

- Face-to-face outreach by a Health Plan directed at Medicaid clients or potential enrollees – including direct or indirect door-to-door contact, telephone contact or other cold-call activities – is prohibited
- Cold-call outreach is prohibited (both in person and by telephone) in all outreach activities – prohibition extends to network providers

May Educate About Specific Plan

- Clients must be made aware of all Heath Plan choices
- A flyer/letter template is posted on HFS website to use in provider offices
- If provider chooses to prefer a Health Plan in the flyer/letter, may add a paragraph to the flyer/letter indicating the preference; however, the preference must result in benefit to the client and not only to the provider
- The flyer/letter must include the following statement: "To learn more about your health plan choices, please contact Illinois Client Enrollment Services at 1-877-912-8880 or visit www.EnrollHFS.Illinois.gov".

May Participate in Community Events

- Health Plans may host or participate in community health awareness events and health fairs
- But all Health Plans in the region must be given opportunity to attend at least 30 days in advance of event
- It is responsibility of Health Plan to advise the event planner that all plans must be invited in order for the Health Plan to accept the invitation

Important Contacts

- Two ways for clients to enroll in a Health Plan
  - by going online at www.enrollHFS.Illinois.gov or
  - by calling Client Enrollment Services (CES) at 1-877-912-8880

- Requests for review and approval of education, outreach and marketing materials:

  HFS Bureau of Managed Care
  HFS.hlthplanoutreach@illinois.gov

Types of organizations referred to in these responses:

Health Plan:

ACE **Accountable Care Entity (ACE)** - provider-based organizations on a three-year path to operating a full-risk capitated plan. Within the first 18 months, medical and other services are paid on a fee-for-service basis.

CCE **Care Coordination Entity -** a collaboration of providers and community agencies, governed by a lead entity, which receives a care coordination payment with a portion of the payment at risk for meeting quality outcome targets, in order to provide care coordination services for its Enrollees. Medical and other services are paid on a fee-for-services basis.

CSN CCE **Children with Special Needs Care Coordination Entity** - provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis. Enrollees in a CSN CCE will be limited to children that the Department has identified through claims data or other information as having complex medical needs.

MCCN **Managed Care Community Network -** an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services for Medicaid clients. They are paid on a full-risk, capitated basis, and therefore pay all claims for services for the enrollees in their Health Plan.

MCO **Managed Care Organization** - a health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.). They are paid on a full-risk, capitated basis, and therefore pay all claims for services for the enrollees in their Health Plan.

It is expected that providers with enrollees in any of the Health Plans will work with the Health Plan Care Teams to coordinate care for enrolled individuals.

	Category	Question	Response
1	Roll-out, enrollment, mailings	I was unable to print out all the useful information in the webinar. Can you send me a link so I can try to do this again?	All of the information from the webcast can be found on the Department's website in the care coordination section at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx
2	Roll-out, enrollment, mailings	Is there an official start/effective date for clients based upon when mailings are distributed to Medicaid clients?	The mailing schedule that is posted on the Department's website reflects the first date that mailings will begin in an area for all eligible clients. That is the date that clients can begin to voluntarily enroll. Auto-assignments for clients that do not select a health plan will be effective approximately 60 days after their initial mailing.
		When will recipients of the All Kids program receive letters stating they need to pick a Managed Care program? Is there a specific deadline for those recipients? When will their Manage Care begin?	
3	Roll-out, enrollment, mailings	Can you share the link to this information on the roll-out schedule?	See the "Managed Care Expansion Mail Schedule" that is posted (and kept up-to-date in case of changes) on the Department's website for a week-by-week schedule for the counties where clients will begin receiving enrollment mailings. The link is http://www2.illinois.gov/hfs/SiteCollectionDocuments/062714_mailsched.pdf This schedule reflects the earliest date mailings will begin by county. The Department is not releasing the schedule by zip code, as the mailing will ensue in all zip codes within a county randomly.
		When is the anticipated date for letters to start going out in Chicago for ACE's?	
		When will the patients receive the enrollment packet in Lake Co?	
		I know that the area East of St. Louis is going through their transition to mandatory managed care now, and that Chicago will be last. Can you identify the times of the rollouts for the 5 major areas?	
		Will providers be alerted when patients in their county or zip code receive their enrollment packet mailing?	
		Where is the list of roll out dates for different areas listed? We want to have an idea of when clients in our area (North side of Chicago) will be receiving their letters for enrollment for ICP? What is the website where we can get this information?	
		Where can you find the list of when the packets will be mailed out for each county? We are a pediatric office in oak lawn, Illinois which is in cook county, keep getting asked when we can expect all these changes.	
		Will there be any more details about when letters will go out to Cook county patients (i.e., by zip codes)?	

	Category	Question	Response
		Have children in Cook County already started being auto-assigned to a MCO?	
4	Roll-out, enrollment, mailings	For the counties that are listed as the areas to receive mailings, what is the priority order? Are they all mandatory counties that are listed and voluntary counties are not included in the first scheduled mailings? Is there a different marketing approached expected for clients residing in voluntary counties?	The mail schedule posted is for enrollments in mandatory counties only. Information in non-mandatory counties regarding expanded health plan choices will begin to be mailed to clients in Spring 2015.
		We are in a voluntary area but in one of the ACEs. Will Medicaid members in voluntary areas receive enrollment packets or any type of communication from HFS that explains they have a new option in Medicaid?	
5	Roll-out, enrollment, mailings	Based upon mailing schedule to Medicaid clients, are there targeted effective dates in which membership would be effective or an overall effective date for the FHP program?	The dates on the mailing schedule represent the dates that the first enrollment packet will begin to be mailed to clients in that area. Clients have 60 days from the mailing date on their enrollment packet to make a choice of health plan and PCP, or they will be assigned to one. The date that mailings begin in each area is considered the official start date for the program, and clients may call the Illinois Client Enrollment Services (ICES) on that date to make a selection if they do not want to wait for their enrollment packet.
6	Roll-out, enrollment, mailings	When will the client packet be available for providers to view?	Enrollment packets will be available for each region on the first date that packets are mailed in that area.
7	Roll-out, enrollment, mailings	For patients in the mandatory managed care regions who want to keep their current PCP, is there a way, today, for them to select their current PCP, ahead of the coming rollout? If yes, how does that work?	No, please see the mail schedule for the earliest possible date an individual can select a health plan and PCP in their county. Once the mailings in their county begin, the clients can phone the ICES to make their selection if they do not want to wait for their enrollment packet.
8	Roll-out, enrollment, mailings	When will recipients in Whiteside County be enrolled in the ACA or CCEs?	Whiteside does not fall within the mandatory regions. The counties in the mandatory regions are the initial focus of the managed care expansion. However, there will be an ACE and a CCE in Whiteside County that clients may select at a later time. Information in non-mandatory counties regarding expanded health plan choices will begin to be mailed to clients in Spring 2015.

	Category	Question	Response
9	Roll-out, enrollment, mailings	My question is about the expansion mail schedule: for the Cook roll-out, can you explain the difference between the Sept 8, Sept 15, Sept 29 and Oct 6 populations? If you are dividing Cook population into four groups, how are you doing this?	The initial mailings to FHP/ACA clients in Cook County are spread out over several months. The September 8th mailing begins in Cook and DuPage counties. September 15th begins the mailings in Lake County and continues ongoing mailing in Cook County. September 29th begins the mailings in Will County and continues mailing in Cook County. Mailings in Cook County continue from October 6th through December 31st.
10	Roll-out, enrollment, mailings	How long does a patient have to change plans after selecting a plan? How long does a patient have to change plans when auto-assigned to a plan? If its 60 days to select a provider, another 30 days to auto assign and then 90 days from the first day of enrollment in the plan, patient technically has up to 180 days until she is truly locked in after receiving initial mailing? If a patient selects a plan then the 90 day clock begins on the first day of their active enrollment on the plan? I think would be good to clarify this as some questions in the care coordination came up about timing.	Whether a patient voluntarily enrolls or is auto-assigned, they have 90 days from the first day of effective enrollment to switch health plans before they are locked in for the year.
11	Roll-out, enrollment, mailings	Can a client opt out of Care Coordination & keep traditional Medicaid if they want to choose to do so?	No, all clients not otherwise excluded are required to enroll with a health plan.
12	Roll-out, enrollment, mailings	If a child with complex medical needs (insured by All Kids) currently receives care at a different hospital (e.g. Advocate LGH, Hope, UIC, Stroger) and they are not in DSCC, will they be required to switch to one of the 3 CSN CCEs? (even if these sites are further from their home and/or logistically more difficult?)	Children with special needs will be able to choose from all of the health plans serving these children -- not just the 3 CSN CCEs -- including the health plans serving the FHP population in their area —MCOs and ACEs.
13	Roll-out, enrollment, mailings	Are children with complex medial needs allowed to “opt out” in order to continue with their same specialists?	There is no “opt-out” option for non-DSCC children. Children with special needs will be able to choose from all of the health plans serving these children, including MCOs and ACEs serving the family health plan population, in their service area.
14	Roll-out, enrollment, mailings	Will families be informed that CSHCN who are enrolled in DSCC are exempt from Coordinated Care? How will this occur? Is HFS planning to require that all children on Medicaid who are diagnostically eligible for DSCC be identified and referred?	Clients under the care of DSCC are excluded from mandatory enrollment. They will not get an enrollment package mailed to them and will be told that they cannot enroll with a health plan if they call the Illinois Client Enrollment Services.

	Category	Question	Response
15	Roll-out, enrollment, mailings	Currently, many of our Registration staff are certified counselors for the ACA and the Insurance Exchange. They assist people with signing up through the marketplace and if the person qualifies for Medicaid, it sends them to ABE and they assist in that sign up. The marketing guidelines say we cannot assist with enrollment. Do you consider what we currently do as "enrollment"?	No, the guidelines apply to enrollment into a health plan, not an application for Medicaid.
16	Roll-out, enrollment, mailings	What is the length of delay period in sign up and approval for care through the process? Some have stated applying in April and still have not had any response.	Enrollment in a health plan commences once a client is approved for Medicaid coverage.
17	Roll-out, enrollment, mailings	If a patient resides in one of the "Other" counties not listed in this roll-out group, can they voluntarily choose one of the MCO's? When will this be mandated in the "Other" counties?	Clients residing in non-mandatory counties will continue to enroll in Illinois Health Connect, and if an MCO is operating in that county, they may choose to enroll in an MCO. Information in non-mandatory counties regarding expanded health plan choices will begin to be mailed to clients in Spring 2015.
18	Roll-out, enrollment, mailings	If a person lives in one county but receives medical care in a county that has different providers available what is a client to do?	Health plans will have provider networks that extend beyond the region for which they are contracted. Enrollees are not restricted to only providers in the county they reside, so long as the provider is in the health plan network.
		What does this mean for providers and clients not in one of these regions? How do we move forward? How do we proceed for clients who live in one of the regions but the provider is outside of the region?	
		What about those facilities or professionals that are not included in one of the regions. If a patient resides within a required region, but sees a provider outside of her region, how is that going to be handled?	
		If we are in LaSalle County where there is no managed care organization mandated, and we see someone from (for example) the Chicagoland area, will we have to have a contract with the Chicagoland managed care organization? Or can we see these patients with no problem? Thank you.	

	Category	Question	Response
19	Roll-out, enrollment, mailings	As providers, are we going to receive a packet with option/ plans - networks to choose from? We cannot contact a patient`s asking them what plan they are in, they usually asking us if we participating in a network and certain plan. Should we as providers choose network first and then patient`s have the option to make a choice. It`s still confusing We are a DME company. Are those HMO required to sign up small suppliers? Who determines which suppliers will be in network and which will not. Why can't we get answers from anyone.	The provider network contact person for each health plan is listed on the Department's care coordination website at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx Providers are encouraged to contact the various plans regarding participation in their networks. Providers should contact health plans to discuss participation. The health plans have been actively recruiting for provider network participation based on their various models of care and needs of their members.
20	Roll-out, enrollment, mailings	If a patient lives in a mandated county, but their provider is NOT in a mandated county (a contiguous county to a mandated county), can they continue to see their provider. We are an OB office in a non-mandated county, but we do see patients from a mandated county.	The requirement to enroll in a health plan is based on the address and county of the client, not the provider. Therefore providers seeing clients in mandatory counties should participate with the health plans in their area.
21	Roll-out, enrollment, mailings	In the non-mandated regions of IL will people start being locked into a plan for a year starting January 2015 or will they be able to still switch plans every 30 days?	Clients residing in non-mandatory counties will continue to enroll in Illinois Health Connect or an MCO if available in their county. In IHC a client may change PCPs once every 30 days. It is anticipated that beginning in the Spring of 2015, clients will begin to receive notice that they will either select IHC or a health plan, depending on the county in which the clients resides. Once enrolled, the client will have a 90 day switch period and will be locked into their choice for one year.
22	Roll-out, enrollment, mailings	From my experience when patients had to choose a PCP through Illinois Health Connect, that they either did not read the letter they received, maybe didn't understand it or did not act on it. Until they needed services and found out they were not able to see us did they do anything. I am wondering if your cut off of 90 days is flexible as I think we will see the same problems with patients making choices. I'm not sure the "with cause" would be sufficient in this case.	The 90 day change period is a firm timeframe. The Department urges providers to reach out to their patients through the use of the template letter that providers may give to their patients to let them know in which health plans they will participate. That template can be found on the Department's website at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx under the Care Coordination Roll Out Plan heading.
23	Roll-out, enrollment, mailings	Does the auto-assignment algorithm take into account keeping a parent/caregiver and their child within the same plan/network and/or PCP?	Yes, the algorithm will look at the health plan of the individual on the case that is closest in age to the enrollee.
24	Roll-out, enrollment, mailings	Could you review an example or two of when a client may change a plan at anytime if they have cause?	Disenrollment for cause is handled on a case by case basis and must be approved by the Department; it is anticipated to rarely occur. An example would be if a

	Category	Question	Response
		Upon termination of a contractual relationship between an MCE and a PCP, what mechanism is in place to allow the affected beneficiary to choose another MCE during the lock-in period if the beneficiary wishes to retain his current PCP?	client developed a condition during enrollment with one plan that only a sub-specialist that is only contracted with another plan could serve. In this instance, the current health plan would have to try to provide these services out-of-network but if that is not achieved, the Department would consider a disenrollment and re-enrollment for cause. Termination of a PCP/health plan relationship does not necessarily mean a client would have to choose a new health plan. The client would be given the choice to choose a new affiliated PCP within their current health plan. The Department is exploring developing a notice to enrollees that they can switch health plans if the PCP/MCO relationship terminates.
25	Roll-out, enrollment, mailings	I noticed that the CEB's will educate and I'm wondering if the health plans will be allowed to conduct an in-service session with the CEB's. The side by side comparison sheets does not contain enough information to make an informed decision.	There are no plans at this time for an in-service session with the Illinois Client Enrollment Services (ICES) staff. While the Department has used this process in the past when there were only 2-3 plans, it is not feasible with the number of health plans participating. The ICES has each health plan's provider network information, in addition to the comparison sheets, that they use to educate clients as needed. The ICES will also refer a client to a health plan for additional information specific to that health plan.
26	Roll-out, enrollment, mailings	For individuals who call the enrollment broker, will the broker point out who is your PCP on record and which plans he/she is in. Will the CCE for complex kids also be in the ACE algorithm?	The ICES customer service representative will ask the client who they currently see or who they want to see for their PCP, and will educate the client based on their choices. The CCEs for Children with Special Needs will be included in the algorithm.
27	Roll-out, enrollment, mailings	What sort of plan will someone from the Family Health population who lives in a Mandatory Enrollment Area that has not been targeted by an ACE be enrolled in?	In a mandatory area where there is no ACE participating, the options will include MCOs and MCCNs, where MCCNs are available. Please refer to the map posted on the Department's website to view which health plans are available in each county. http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx
28	Roll-out, enrollment, mailings	What are the steps a CountyCare client should take if they want to switch health plans before their mailing goes out in 2015? Are they able to do so?	Yes, when enrollment in Cook County begins, clients enrolled in CountyCare can call ICES to switch health plans. They do not need to wait for their enrollment packet.
29	Roll-out, enrollment, mailings	What are expected wait times if an individual is calling in for information? How was the calculation determined?	Wait times in the ICES call center will depend on the volume of calls coming in at that time. ICES will monitor the call center call volumes to minimize extended wait times.
30	Roll-out, enrollment, mailings	Will CCE clients be enrolled in IHC as well as the CCE?	Clients will be enrolled in the CCE; the CCE will be their health plan. PCPs that participate in a CCE or ACE network are required to be enrolled as PCPs in Illinois Health Connect for system and payment purposes.

	Category	Question	Response
31	Roll-out, enrollment, mailings	For Cook County, for the medically complex pediatric population, will all CCE eligible patients letters go out in early September, or will those letters go with the phased in roll-out with the rest of cook county?	The initial mailings that will include the CCEs for Children with Special Needs as a health plan choice will begin September 1, 2014. It may not be concluded in one month.
32	Roll-out, enrollment, mailings	Can you please explain the distinction between ACE's and MCO's if both entities are available in a region? I am from Champaign County, and there are 2 health plans and 2 approved ACE's for our county. Do consumers enroll in both an ACE and a health plan, or do they choose one or the other network?	Enrollees in Champaign County will choose one of the four health plans. Each ACE and MCO is its own entity.
33	Roll-out, enrollment, mailings	Do all family members (at the same address) have to sign up for the same plan?	All family members do not have to choose the same health plan.
		Can children be under different plans from their parents?	
34	Roll-out, enrollment, mailings	What happens if a newborn's mother is not enrolled in Medicaid? Specifically, a newborn who is admitted to the NICU , has a long stay, so is enrolled in SSI and then in Medicaid? Will this newborn get auto-assigned?	Children with Medicaid and SSI will have the option to voluntarily enroll with a health plan; they will not be auto-assigned to a health plan.
35	Roll-out, enrollment, mailings	Will these changes result in no Direct Access? For example a newborn had 90 days direct access from birth. They could be seen by any Physician. Or a child could go to any physician to receive immunizations. Sounds like this ends with the new programs.	Providers must determine the enrollment, and therefore the payer source, for their clients prior to services being provided. Each health plan will have their own requirements regarding immunizations.
36	Roll-out, enrollment, mailings	Will there be a grace period for clients that come to our facility almost daily that will become eligible at any moment and we will not know when they become eligible?	Providers must determine the enrollment, and therefore the payer source, for their patients prior to services being provided. This information is available on the Department's MEDI system through an Electronic Data Interchange (EDI) vendor or through the Department's Automated Voice Response System (AVRS). Providers should check eligibility prior to providing services to determine if a patient is enrolled with a health plan.
		How do we check to see which Medicaid plan a patient is in?	
		How will we identify which managed care entity plan a patient has?	

	Category	Question	Response
37	Roll-out, enrollment, mailings	What will happen with regards to a patient's coverage status on the 61st day following the date of the letter. Hard to imagine all will be automatically enrolled in a plan immediately following the 60th day. What will show in MEDI?	Enrollment will be reflected in MEDI when the system is updated with current or future enrollment. As the mailings are staggered on an individual basis, so is the 60th day in which auto-assignment will occur. Enrollment in an MCO and MCCN is always effective on a calendar month basis. If the choice or assignment occurs early in the month, the enrollment is effective the first of the following month. If it is received mid or late in the month, the enrollment is effective the first of the second month. For example, a choice of an MCO on the 8th of the September would be effective on October 1st, while a choice of an MCO on the 18th of September would be effective November 1st. Enrollment in an ACE or CCE is effective within 24-48 hours of the choice.
38	Roll-out, enrollment, mailings	How often will patients be able to change providers within the managed care plans or will it be determined by the plans? What if the parent does not like the pediatrician/physician that he/she picks? Can they change easily? Can they change frequently? Without moving as an excuse.	The ability to change PCPs within each health plan will be governed by that health plan. It is the Department's experience that the MCOs rarely limit PCP changes if the new PCP can better address the needs of the patient. Clients enrolled in an ACE or CCE will be able to switch PCPs, limited to one switch per month.
39	Roll-out, enrollment, mailings	Jim stated that Cook County/Chicago has not yet started this process, but we have had several consumers living in our IDD CILA program in those areas that have received mailings stating that they must enroll in a plan. Please clarify.	The enrollment of FHP/ACA clients in Cook County has not yet started. The Integrated Care Program (ICP) began in May 2013 for Seniors and People with Disabilities in suburban Cook and the collar counties, and enrollment in Chicago is currently underway, which may explain their mailings. Additional information on ICP can be found at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/icp/Pages/default.aspx
40	Roll-out, enrollment, mailings	Will Harmony or other VMCOs receive auto- assignment of patients?	Yes, they will receive auto assignment in the mandatory counties. The voluntary managed care program expired on June 30, 2014. The plans previously participating in that program, Harmony, Meridian and Family Health Network, now have a contract for the Family Health Plan and ACA population as a part of the roll-out. Their enrollees under the VMCO program were automatically converted to the new program, and will receive a mailing offering them all of their health plan options.

	Category	Question	Response
41	Roll-out, enrollment, mailings	You stated that patients will be locked in and cannot change is there a once a year enrollment period or something similar?	There is an annual open enrollment period when enrollees can change their health plan. This period is based on the enrollee's anniversary date with their current health plan. They will receive a letter between 70 and 90 days prior to their anniversary date explaining their options. This will allow for a change of health plans to be effective on their anniversary date. If no action is taken by the client, they will remain enrolled with their current health plan for another 12 month period.
42	Roll-out, enrollment, mailings	The Client Enrollment Benefits line, is there multiple languages offered on the other end?	The ICES has bilingual customer service representatives for English and Spanish. In addition, they use a language line to assist clients that speak any other languages.
43	Roll-out, enrollment, mailings	I have concerns about the future with managed care for these patients as most of them have gotten "free" care. Will there be someone to explain to them they will not get the same services as before? My concern is that patients need to be more educated on what the managed care plans are and encouraged to call in and speak with someone about their options and their plans.	The ICES is equipped and able to explain how the various health plans operate, and the changes that clients will encounter. All clients are directed in their enrollment packets to call the ICES. In addition, the health plans themselves will send their new enrollees a member handbook which explains how the health plan operates, how the health plan will coordinate their care, and how to access services.
44	Roll-out, enrollment, mailings	We have some clients who are developmentally disabled or chronically mentally ill that need our advocacy assistance to help them understand and make informed choices. Are we able to help those individuals enroll in a plan? If not, who can they have help them with this process?	Anyone who has the legal authority to assist a Medicaid client may assist them to enroll in the health plan of their choice. Proof of this authorization will be required.

	Category	Question	Response
45	Roll-out, enrollment, mailings	We are a skilled nursing facility in Illinois, I have a family member whom the state picked Molina for their mothers plan. The entire family is from India and does not understand this process of the HMO's. The family wanted to change the plan to Health Connect. Molina is stating that they cannot due this as this resident's benefits started 4/1/2014. The facility was not notified of this via mail, phone call, etc, facility was not informed of this plan for this resident until 6/2014. Why is the state not notifying the nursing facilities of these changes that have been made on their long term care resident's payer status? As a home healthcare provider, how do we know which plan a patient is enrolled in? Is there a portal that will tell us which we type the name, Medicaid/Medicare ID and find out which plan the patient is enrolled in?	The Department released a Provider Notice on 6/23/14; it is posted on the Department's website. Providers must check eligibility on the Department's system (thru MEDI, EDI or AVRS) on a regular basis. The Department recommends that nursing facilities check prior to the first of each month. MCO and MCCN enrollment is always effective on the first of a month. ACE and CCE enrollment can occur at any time during the month, and always ends at the end of a month.
46	Roll-out, enrollment, mailings	We have clients who do not speak English or Spanish and the letters sent out will not be understandable by them. What steps have been take to ensure that non-English and Non Spanish speaking clients are being reached out appropriately.	The enrollment packet is available in English and Spanish. The ICES has bilingual customer service representatives for English and Spanish. In addition, they use a language line to assist clients that speak any other languages.
		What if the client does not speak English? Is enrollment available in other languages?	
		Will the 877 number for enrollment have client brokers who speak Spanish and Korean?	
		Will materials be available in Spanish language? Some of our clients have gotten letters, and they are in English.	
47	Roll-out, enrollment, mailings	Will substance use and mental health treatment providers be listed on the Client Enrollment Broker for each plan, so people can see ahead of time which network their current provider is already in?	Yes, each health plan will identify their network providers for use by the ICES for education and enrollment activities.

	Category	Question	Response
48	Roll-out, enrollment, mailings	If someone in Chicago becomes eligible for Medicaid prior to September, what are their health plan options at that time? Will they also get an enrollment packet in September? Basically, what is the transition process for people who become eligible before the new mailing/enrollment process? If an individual applies for Medicaid tomorrow and is approved, his next step is to contact the CEB and select a plan. After Medicaid eligibility is approved, where can the individual go in the interim for medical care?	Clients newly determined eligible for Medicaid will receive an enrollment packet in the mail from the ICES. Prior to their selection of a health plan and its effective date, newly eligible Medicaid clients can access services through the traditional Medicaid fee-for-service program with any provider that accepts Medicaid.
49	Roll-out, enrollment, mailings	I thought that CCE's are unable to take on children at this time and can only take adults. Did I misunderstand the Q&A just stated?	There are 2 types of CCEs; those that coordinate care for SPDS and those that coordinate care for children with special needs.
50	Roll-out, enrollment, mailings	If a Medicaid enrollee who is currently in a MCO, will be assigned to that MCO if the enrollee does not make active choice during the enrollment period? In other words will the State assign that enrollee to a different MCE in the default enrollment process?	The auto-assignment algorithm process will take into consideration a client's current health plan relationship.
51	Roll-out, enrollment, mailings	We are a specialty provider of newborn hearing testing, outpatient facility separate from the hospital that evaluates infants who fail the newborn hearing screening at birth. How will newborns be assigned a plan and how would a provider know what that plan is? We are dealing with very young newborns that often are not fully enrolled in Medicaid to begin with since we see them when they are only a few weeks old. Will specialty providers need to be enrolled in all the different managed care plans in order to see these newborns?	Yes, specialty providers are encouraged to participate in all health plan networks to continue serving Medicaid beneficiaries. If a newborn's eligibility is not showing in the Department's eligibility system (MEDI, EDI or AVRS), providers should check the mother's eligibility to find the newborn's plan enrollment, as newborns will be automatically enrolled in the mother's MCO or MCCN. If the newborn's mother is enrolled in an ACE or CCE, the mother will receive an enrollment packet from ICES to pick a health plan and PCP for newborn.

	Category	Question	Response
52	Roll-out, enrollment, mailings	I have been trying to find someone who will tell me which ACEs and health plans are enrolling children 0-18 as well as their caregivers. I'd also like to know which ACEs and Health plans are enrolling ACA adults. If someone from the community today, was a relative caregiver with children on Medicaid, which ACEs or plans would they be able to enroll in, assuming they lived in Peoria and/or Cook County?	All ACEs will be enrolling the Family Health Plan Population which includes children, Parents/Caretaker Relatives, Pregnant Women. Not all of the ACEs in Cook County will be enrolling ACA adults. The Illinois Partnership for Health will be enrolling ACA adults in Peoria. Please review the materials on the HFS website. The expansion map located at the link below provides the information on which plans are operating in each county and will be a choice for the Family Health Plan population and the ACA adults: http://www2.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf
53	Roll-out, enrollment, mailings	It would be most helpful if you could also post a copy of the envelope that the Enrollment letters will be mailed out in. We could then alert our clients to look for the envelope/enrollment letters.	The Department will work on posting a sample envelope on the ICES website.
54	Roll-out, enrollment, mailings	Is it possible for me to close my panel to Medicaid but open up for special situations such as siblings?	Within Medicaid FFS and IHC, a provider may limit their Medicaid panel size. They will not be able to restrict panels to existing patients only. How tightly they may control their panel size when they contract with an MCO or MCCN is governed by the contract with that entity. Most MCOs and MCCNs allow physicians reasonable control over their panel size.
55	Roll-out, enrollment, mailings	Can you repeat the enrollment rule for FQHC? Just verify - Member can enroll just stating FQHC and not state an individual doctor name? Erie providers were told that if they don't see their name listed in the CEB/client enrollment with the correct plan, patient can just use the name of the Chief Medical Officer to get into the correct plan. This will obviously be very confusing since the patient will end up at Erie, but not actually see the Chief Medical In regards to the ICEB, was your answer reflective of CCE's as well? It was thought that all providers of an FQHC has to be enrolled in IHC and be put into the system to be able to accept enrollees. Can just the site be listed and an enrollee sign up with the FQHC as the provider versus an individual provider within the FQHC? I would appreciate clarification.	An individual can identify the name of the FQHC for enrollment. Enrolling in an FQHC does not require an individual provider name. Although the ICES tries to get the names of all individual doctors at an FQHC, clients are actually assigned just to the FQHC and do not need to ask for the CMO. They can just ask for the FQHC. Each health plan provides their provider network details to the ICES. The ICES will use the provider network detail provided by each health plan to educate and enroll clients.

	Category	Question	Response
56	Roll-out, enrollment, mailings	Will children's CCEs be enrolling the majority of children with complex needs or will the ACEs and MCOs be receiving the majority of children with special needs? (This question stems from a lot of anxiety from Pediatricians and the fact that Lurie's has been resistant to enroll new providers stating that of the nearly 45K children with special needs in Illinois Medicaid, they will only be receiving 5K, OSF 5K and La Rabida 1K so providers need to realize that the ACEs and MCOs will be receiving the majority of these children with special needs)	Children with special needs will have the option of joining an ACE or MCO, and in certain counties a CSN CCE. It is anticipated that many children will not join a CSN CCE due to factors such as the geography of the plan and provider availability in the network. It is likely that many will be in plans other than the CSN CCEs.
57	Roll-out, enrollment, mailings	If providers participate in more than one plan, can they indicate a preferred plan for their patients (who do not make an active choice) to be auto-assigned to?	No.
58	Roll-out, enrollment, mailings	I live in Montgomery County and the doctor for my children is in Sangamon County. Will I still be able to have the same doctor or will I need to find them another? Will there also only be specific doctors that we can and cannot go to?	Montgomery County is not in a mandatory managed care area, so you will not be required to join one of the FHP/ACA health plans. You and your children will have the option of remaining in the Illinois Health Connect program, or enrolling in the one ACE that will serve that area, Illinois Partnership for Health.
59	Roll-out, enrollment, mailings	In the counties changing to managed care, are 100 % of Medicaid members being transferred as state law only calls for 50%? In particular for routine vision and eyeglasses, for those of us who have been Medicaid providers for years and now are restricted from being providers for the new plans, there is a certain injustice I believe.	In the mandatory managed care regions, close to 100% of all Medicaid clients will be required to choose a health plan. This choice will include MCOs, and may include MCCNs, ACEs or CCEs. Services for ACE and CCE enrollees will continue to be reimbursed through the Department's regular fee-for- service system (for 18 months, in the case of ACEs). MCOs and MCCNs are required to have an adequate network of providers to ensure their enrollees have access to covered services; therefore they will be contracting for routine vision and eyeglasses. Each health plan develops their own network of providers, the Department encourages the providers to sign up with as many health plans as possible.
60	Roll-out, enrollment, mailings	To assist in the development of marketing/engagement plans in educating providers, has the state provided a template of the communication piece that can be distributed within health systems as providers are working to educate their Medicaid clients/patients?	The Department has released a template letter that providers may give to their patients to let them know in which health plans they will participate. That template can be found on the Department's website at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx under the Care Coordination Roll Out Plan heading.

	Category	Question	Response
		When can we anticipate the Sample letter for PCPs to utilize? Also, can they list the MCEs that they are with vs. all? I feel that in order to have that member continue care, it is best to only list the MCEs that the PCP is with (they will already get a letter from HFS noting all MCEs).	
		It is difficult to find the link to flyer and letter template on your website. Can you please provide a link?	
		You mentioned in your presentation that if a provider wants patients to use a specific managed care entity, they have to go through a certain procedure. Can you please clarify that process? Thank you.	
		When I go to the enrollhfs.illinois.gov site, I just see options to compare plans, find providers, or look at Program Materials or links. The Program Materials does not seem to include the sample letter you talked about in this presentation. It shows sample letters for the 30 day and 60 day letters, but not the kind you seemed to be describing. Please clarify what the web address is and where to find the things you mentioned such as the map of roll out, the sample provider letter, etc.	
61	Roll-out, enrollment, mailings	Did you mention marketing restrictions imposed on service providers?	Health plans and providers serving Medicaid clients are governed by federal Medicaid managed care law, specifically 42 CFR Part 438. 104. The Department has released a template letter that providers may give to their patients to let them know in which health plans they will participate. That template can be found under the Care Coordination Roll Out Plan Heading on the Department's website at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx
62	Roll-out, enrollment, mailings	Are providers allowed to contact their current patients via phone to inform them of the MCO plans that they will participate in?	No. The Department has prepared a written template of a letter that may be mailed or handed to patients. Providers and other entities may not outreach to patients through other means, including calling clients directly, as that is cold call marketing.
63	Roll-out, enrollment, mailings	How would a PCP know if a child is CCE eligible and therefore be able to counsel a family on the benefits of joining a CCE?	PCPs may offer information to their Medicaid clients through the use of the template letter the Department has made available on its website.

	Category	Question	Response
		I wanted to know if Medicaid clients are coded in any particular way in MEDI so that providers can tell if their patients are or will be asked to pick one of the new managed care plans and what program they belong to (ICP, MMAI, Family Health Plan, ACA adult) vs. not being mandated or required to select a managed care plan at this time or is enrollment into one of the plans only evident once a client selects a plan or is auto assigned to a plan?	There is no specific indicator that the PCP can use to identify who will be required to enroll; however, most children, parents/caregivers, seniors, persons with disabilities and ACA adults receiving Medicaid in the mandatory regions are required to enroll.
		Are all adults with Medicaid to be transferred to MCO ? or just patients with disability and elderly patients and CCN patient?	
		Patients often don't present with enrollment cards. Rockford is one of the areas requiring MCO coverage. Will there be a way for us to know what patients are exceptions that don't require a MCO/HMO?	
		Can you tell what 'type' of Medicaid plan a pt has on MEDI? ie, TANF, vs CCE, complex kidz, etc	
64	Roll-out, enrollment, mailings	Is a draft version of the overall letter being mailed to Medicaid clients regarding the requirement to enrollment in some form of a managed care plan being provided to providers to reinforce and educate clients on managed care enrollment requirement?	A sample of all materials that are being mailed to Medicaid clients can be found on the ICES website once a region begins enrollment. That website is: http://enrollhfs.illinois.gov/. Information for each region will be posted when that region begins enrollment.
		I am wondering if there is a central place where I can obtain the approved outreach/education activities materials for the MCO's in the Rockford and McHenry regions (Community Care Alliance of Illinois, Family Health Network, IlliniCare, Meridian and Illinois Partnership for Health)? I looked on the HFS website, and could not find any. If there is not a central place to identify these materials, can the materials approved through HFS be emailed to me?	
		Can providers view a sample enrollment packet? Could one be provided to the MAC?	

	Category	Question	Response
65	Roll-out, enrollment, mailings	How come when I look up my name on EnrollHFS, the information seems inaccurate? Will they be adding more plans? I don't see County Care as an option.	Today, the information on the ICES website only consists of the counties for which enrollment is open. As the enrollment roll-out progresses, this information will be available for additional areas. If information listed is inaccurate, the provider should contact the health plan to update their provider file. They are sending to ICES to use for education and enrollment activities.
66	Roll-out, enrollment, mailings	In what region(s), will the MCCN(s) be operational? The MCCNs are not identified on the latest statewide rollout map (June 17, 2014).	There are three MCCNs operating in Illinois: • Family Health Network- serving FHP/ACA clients in the Greater Chicago and Rockford Regions • Community Care Alliance- serving SPD clients in the Greater Chicago and Rockford Regions • CountyCare- serving the SPD and FHP/ACA clients in Cook County. The current map posted on the Department's website, dated June 25, 2014, contains this information.
67	Roll-out, enrollment, mailings	Does PCP relationship take priority? If a client has a PCP and the PCP is aligned with an ACE that has reached its goal, will the PCP relationship still result in an assignment to the ACE first? Will the auto-assignment process give preference to any particular model; i.e. will patients be auto-assigned to ACEs before MCOs? For patients who do not actively make a plan selection, is it the Department's intent to transfer a provider's panel to the same MCE? If a PCP belongs only to an ACE, will existing patients be auto-assigned to the PCP's affiliated ACE?	The algorithm to assign a client that has not chosen a health plan takes into account many factors, the first of which are maintaining existing health plan and provider/patient relationships. The algorithm will also maintain capacity limits of PCPs. Therefore, in the example given, in order to maintain the provider/patient relationship, the algorithm would look to see if the PCP had availability in other health plans. In addition, the algorithm will favor enrollment in ACEs pursuant to Public Act 98-104. The algorithm does not assign by a provider panel; auto-assignment is based on a client's individual circumstance.
68	Roll-out, enrollment, mailings	With respect to the brochures used by providers to inform patients of their networks, does the provider need to state their reason (e.g., the benefit to the client) for the network/plan preference on the brochure?	Yes.
69	Roll-out, enrollment, mailings	If the health plan communicates to the host that they must extend an invitation to all health plans in that area and host complies but only one plan shows up, can that one health plan still attend the event?	Yes.
70	Roll-out, enrollment, mailings	I do not find my physicians on the Enroll search website. Why isn't there a PCP search application?	There is a provider search application on the ICES website which contains provider networks as submitted to the ICES by the health plans. This information is

	Category	Question	Response
		How do we know is our provider is in the network/plan?	continually updated, but it may not be complete for areas of the State that have not yet begun enrollment. The best way for a client to determine which plans a provider participates in is to ask the provider.
71	Roll-out, enrollment, mailings	Will the current system issues that prevent enrollees switch between CCE's impact the roll out at all or open enrollment?	The Department expects all programming related to enrollment to be in place and operational prior to the July 21st expansion in the Central Illinois region.
72	Roll-out, enrollment, mailings	I am a social worker for a dialysis clinic and I have tried contacting the client enrollment services to ask questions, but they ask for my social security number. Is there a way I could bypass that or is there another number I could call to get questions answered? Also, a few of our pts have been automatically transitioned to MCOs that were not in network with our hospital and they contacted CES and were told that they would be able to change in about a month after the call was made. Will they be penalized while they are transitioning back to an MCO that is network with our services? Will the pts get a big bill since technically they are not in network? Some were told that they have to switch to another provider, but for a dialysis pt, it's not as easy to transition to another service as other services since they have to receive care and can't just switch to another center.	The ICES call center is for the education and enrollment for clients only; it is not for providers to inquire about benefits or member specific questions. The MEDI system or the Department's Provider Hotline (1-800-842-1461) can provide information on client eligibility and current health plan enrollment. Enrollees have 90 days to switch health plans after initial enrollment before they are locked in for one year. Enrollment in an MCO and MCCN is always effective on a calendar month basis. If the choice or assignment occurs early in the month, the enrollment is effective the first of the following month. If it is received mid or late in the month, the enrollment is effective the first of the second month. MCOs and MCCN are required to honor an existing course of treatment for the first 90 days of enrollment if the provider, whether in-network or out-of-network, agrees to accept the health plans standard rate for the services provided and to provide required information to the health plan for quality assurance. Enrollees are not penalized for switching from one health plan to another. Enrollees will not be responsible for any claim payment. Providers must check a patient's eligibility prior to providing services to ensure payment from the appropriate source is arranged.
73	Roll-out, enrollment, mailings	Starting last week we have patients calling stating that today, June 30 is their last day to enroll. We have chosen to be a part both Molina and Meridian here in Madison County, and this information has not been updated and our patients are being told that they can't see us. They are telling us that they received the letter last week, that doesn't seem to be a whole lot of time for decision making.	Mailing for the Metro-East Region began the week June 13th. Clients have 60 days to make a choice before auto-assignment is effective. If you can provide specific information on the client that encountered this situation, the Department will be able to track down the activity that has occurred.

	Category	Question	Response
74	Roll-out, enrollment, mailings	You indicated that a provider can send a letter (after your approval process) to his/her patients indicating a preference for a certain plan, as long there is "something better" about that plan for the patient. What kinds of examples of "something better" for the patient would be acceptable?	Each health plan may offer additional benefits or unique care coordination opportunities to its enrollees that a provider believes would be very useful to his patients. This type of information may be presented to a patient in the template letter (available on the Department's website) as the reason the provider prefers a particular health plan for the patient.
75	Roll-out, enrollment, mailings	We are a DME provider. Previously you said children under DSCC waiver services will not currently be included in the MCO rollout. However if there are children with complex needs that get services that fall under a CCMN's, will the patient's have to move to an CCMN DME provider?	There are many children with special health care needs that are not receiving DSCC waiver services. The health plan options for these children will be CSNCCEs, ACEs and MCOs dependent upon area of service.
76	Roll-out, enrollment, mailings	We are a strictly a Peds practice in Lake County. When should we actually start talking to our patients about this? Is it too early for them to sign up? We have concerns with what hospitals will have contracts.	Per the posted mailing schedule, clients in Lake County will begin receiving enrollment packets the week of 9/15/14. You may distribute the template letter (available on the Department's website) to them for receipt that week, but please continue to check the Department's posted mailing schedule for any updates.
77	Roll-out, enrollment, mailings	How can I disenroll children and adults from the Managed Care due to these people being placed out of state by a sending agency in IL?	When a client address in the system is changed to an out of state address, the system will automatically disenroll the client from a health plan. As a provider, you should ensure that the client change of address is reported appropriately.
78	Roll-out, enrollment, mailings	If only 1 plan is offered in my county, will the recipients be automatically enrolled or do we have to enroll them?	In the mandatory regions, there are at least 2 health plan options in all counties. All enrollments are done through the ICES.
79	Roll-out, enrollment, mailings	I noticed that our provider information is listed inaccurate on your website such as our plans/network and hospital affiliations. How can we update this information? I am confused about what to do if the provider information is incorrect on the HFS Client Enrollment website.	The information on the ICES website is populated from information received from the health plans regarding their network. If a provider finds this information to be incorrect, the provider should work with the health plan under which it is incorrect so that the health plan can get the correct information to the ICES.
80	Roll-out, enrollment, mailings	Are all MCO's/HMO's sending members member cards? Will the MCO & Medicaid member number be identical like it is today?	All MCOs and MCCNs provide health plan member cards to their members. The Medicaid RIN and member ID on those cards are the same.
		Are their Medicaid identification cards going to be labeled or will they have varying cards depending on the actual managed care plan (ie AETNA,BCBSIL)?	Some ACEs and CCEs will provider member identification cards that will include the clients Medicaid RIN.
81	Roll-out, enrollment, mailings	Currently when we query eligibility for Medicaid, we receive information about the MCO/HMO the member is enrolled in. How often will the MCO's update HFS with enrollment data?	MCO and MCCN enrollments are generated by the Department and the ICES, not the health plans themselves. The system is updated on a daily basis.

	Category	Question	Response
82	Roll-out, enrollment, mailings	I work for a mental health community agency and needing some clarification between ACE and MCO and how this affects mental health community agencies providing services to children and adults who were once enrolled in Medicaid now enrolled to a MCO, such as Illinicare, Aetna (insurances that are considered as Integrated Care Plan). Do families/children enrolled in a MCO need to enroll into an ACE? Do community mental health agencies need to develop a linkage agreement with an ACE in order to be reimbursed for behavioral health services?	The ICP is a separate program from the subject of the webcast, the roll-out of enrollment of the FHP/ACA population. All FHP and ACA clients will have to pick a health plan, either an MCO, MCCN, ACE or CCE. Services provided to ACE enrollees will continue to be reimbursed through the regular Medicaid fee-for-service system for 18 months, but providers should coordinate all care through the ACE. Providers of community mental health services are encouraged to participate in networks of ACEs and MCOs - who must all provide behavioral health services to children/family members and ACA adults.
83	Roll-out, enrollment, mailings	Are the MCOs and MCCNs required to enroll both the FHP and ACA adults? WE have had some of these plans tell us they are only going to enroll the FHP population? Same question for the ACEs	The MCOs, MCCNs and most ACEs will enroll both FHP and ACA clients. Two ACEs will enroll FHP clients only (Advocate and Loyola) and one CCE will enroll ACA clients only (NextLevel).
84	Roll-out, enrollment, mailings	I am writing to you in regards to an e-mail that was received Cook County Health and Hospitals system - CountyCare. We were instructed that all plans must be invited in order for them to accept our invitation. We are not quite sure how the procedure works and ask for your guidance in this process.	Outreach guidance, and a contact list for each health plan for this purpose, can be found on the Department's website at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx under the Care Coordination Roll Out Plan heading. This guidance provides "Hosting or participating in community health awareness events and health fairs where all health plans in the region have been given the opportunity to attend at least 30 days in advance of the event. It is the responsibility of the health plans to advise the event planner that all plans must be invited in order for the health plan to accept the invitation. The health plans must send all events to HFS for prior approval. The Department may also participate or provide observation of Health Plan Outreach Guidelines."
85	Roll-out, enrollment, mailings	In regard to the 5 mandatory managed care regions: Rockford, Central Illinois, Metro East, Quad Cities, and Cook & Collar Counties, will 100% of all Medicaid populations (AABD, All Kids/parents, CSN, and ACA) be moved from Medicaid fee for service into one of the managed care entities (ICP's, CCE's, ACE's, CCMN's, MMAI, etc)? If so, would this mean hospital providers in one of these 5 regions should expect nearly 100% of future claim payments to come from a managed care entity and no longer directly from the state?	In mandatory managed care regions, most Medicaid beneficiaries will be in a Managed Care Entity of some type. However, for those in ACEs and CCEs, providers will still receive payments for services through HFS. However, once ACEs convert to risk based capitation in 18 months, the vast majority of payments will come from entities other than the Department.

	Category	Question	Response
86	Roll-out, enrollment, mailings	How do these changes affect a small business practice like ours.	Providers are encouraged to work with the various health plans to participate in their network in order to continue to see your patients.
87	Roll-out, enrollment, mailings	What region will Jo Daviess County belong to?	JoDaviess County is not located in a mandatory managed care region. Illinois Health Connect will continue to be the delivery system in that county.
88	Roll-out, enrollment, mailings	Who is "Client Enrollment Contractor?"	The Illinois Client Enrollment Services (ICES) program is operated by Maximus, as a result of a competitive procurement process under Illinois State law.
89	Roll-out, enrollment, mailings	Could you share this powerpoint after the presentation? It has a lot of great information we'd like to have on hand.	The Power Point presentation is available on the Department's website at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx. The Department encourages you to organize an educational session for the staff in your organization, using the presentation.
90	Roll-out, enrollment, mailings	How was the determination made to do multiple mailings instead of another route such as what Medicare has done to enroll in part D benefits?	Staggered multiple mailings are being used to allow for a smooth transition. This will ensure the Illinois Client Enrollment Services can handle the influx of calls, and it gives the health plans time to reach out to new enrollees in a timely manner.
91	Roll-out, enrollment, mailings	Is there a list of the acronyms and definitions?	At this time there is no separate list of acronyms and definitions posted on the Department's website. The Department will develop and post such a list.
92	Care Coord.	Knowing the MCOs are not required to allow any willing provider into their network, will members be required to change pharmacy providers for specialty products once they elect or assigned an MCO? OR To allow for continuity of care, would the MCO allow the current PA to expire prior to requiring the change of providers?	The prescription drug benefit for ACE and CCE enrollees will continue to be reimbursed through Medicaid fee-for-service (for 18 months in the case of ACEs). Each MCO and MCCN will have its own pharmacy formulary, which must be approved by the Department. MCOs are required to provide coverage of drugs in all classes of drugs for which the Department's fee-for-service program provides coverage. The MCO or MCCN must honor enrollees existing medications for 90 days if the enrollee is in a continuing course of treatment.
		Will all the plans have the same covered prescription drug list as Medicaid or will they all be different? Will I have to switch medications immediately if the plan I choose does not cover my current meds?	

	Category	Question	Response
		As a pharmacy, we have encountered patients who have begun receiving benefits through their MCO. A drug that was previously covered with HFS is no longer covered with their MCO. We have been faced with no period provided by the MCOs, so that we could not provide the patient with even a few days supply of medication while we try to coordinate a change of medication with their physician. This has been difficult for us and the patients. We encourage HFS to look into this.	
93	Care Coord.	Will pregnant women still be able to stay with their OB even though the OB may not be in the network yet. Will MCOs grant continuity of care and pay doctors out of network?	The MCOs and MCCN must allow enrollees to continue care with an out-of-network provider for the first 90 days if under a current course of treatment or in the third trimester of pregnancy.
94	Care Coord.	Will the current Prior Authorization follow the patient to the MCO OR will the provider need to request a new PA from the MCO?	Providers should request a new prior authorization from the MCO or MCCN, but indicate that HFS had given prior approval.
95	Care Coord.	How will Early Intervention work in tandem with the Coordinated Care entities?	Although children in Early Intervention are covered by the Health Plans, Early Intervention services are not. Early Intervention will continue as it operates now through Part C enrolled providers. The only adjustment is that Early Intervention providers and the health plans will need to communicate and coordinate with each other regarding the enrollees care.
96	Care Coord.	How will families be informed of their EPSDT rights when they are in coordinated care?	All health plans are required to send a member handbook to their enrollees. These handbooks contain information regarding covered services, including EPSDT services, and enrollee rights.
97	Care Coord.	Will the nursing home be sent information on which plan the resident selected or will we have access to that information thru MEDI or another web site?	Nursing homes will gather information about their residents' enrollments through one of the methods offered by the Department, MEDI, EDI or AVRS. Some health plans may elect to send a list out to each nursing home identifying the names of residents in their health plan, but that is at the discretion of each health plan.
98	Care Coord.	Will the MEDI system still be used as it has in the past for nursing home residents or will we be notifying the health plan of changes that may occur with admission to hospital, bed holds, or deaths?	Nursing homes should notify both the MEDI system and the health plan when these changes occur. Nothing changes in the way you report information to HFS.

	Category	Question	Response
99	Care Coord.	Our clinic is located in Henry County. With Meridian and IlliniCare, does the patient have to choose a PCP? If so, do they have to see THAT physician only? Will we have to obtain referrals for specialists with either of these plans? Will there be a co-pay with these plans?	All clients must choose a health plan and PCP when they enroll through the ICES. Once they are enrolled with a health plan, they may choose a different PCP by calling the health plan. Each MCO and MCCN has different referral, prior authorization and co-payment requirements. Please contact the health plans in your area to learn more about said requirements.
100	Care Coord.	Can a client choose a health plan but opt out of the "Care Coordinator's" services, and keep the person who is helping them with those items at this time as their care coordinator?	Client may opt out of care coordination services within a health plan. However the health plan will still provide coordination services to the extent possible. There will be no reimbursement for MCO or MCCN enrollees other than through the health plan.
101	Care Coord.	Will our DD patients require prior approval in order to obtain psychiatric services? We currently have to send them to ER for evaluation.	If the service is being provided under the DD waiver, you would follow the procedures as they are set forth now under the DD waiver. If the service is being provided as a medical service under the Medicaid state plan, you should contact the MCO or MCCN to determine if prior approval is necessary.
102	Care Coord.	Are these managed care health plans allowed to place any limits they want on benefits such as outpatient therapies - PT, OT, ST ? We are an outpatient therapy clinic (PT/OT/ST) for children with disabilities located in suburban Chicago - I'm not sure what we need to do in relation to these changes since most of the literature speaks to medical services or services for adults. I am provider of Home Health, hospice, outpatient PT, OT, ST. We do house calls in Cook, Will, Dupage counties. How I can be a better part of the care?	These changes will impact all providers of services reimbursed by Medicaid. The MCOs and MCCNs can generally set their own utilization and prior authorization controls but must provide at least the Medicaid benefit, and generally can be no more restrictive than Medicaid.
103	Care Coord.	This is a Substance Abuse program -- if a client comes from another county and has a PCP from that area -- do we need to contact that PCP for a referral to our program?	You should contact the health plan in this situation to determine if a referral or prior authorization is required, as well as the PCP to ensure your patient's care is coordinated and you are aware of any other course of treatment the patient may be under.
104	Care Coord.	We are a IDTF and we participate with all of the (ICP) programs. Do we need to participate with the ACEs, CCEs and CCMNs programs to see these patients?	Although Medicaid covered services provided to enrollees in ACEs, CSN CCEs and SPD CCEs are still paid FFS (in the case of ACEs, for the first 8 months) and no contract is needed with those entities in order to get paid, providers serving those enrollees should seek a relationship with those entities in order to better coordinate care and improve outcomes.

	Category	Question	Response
105	Care Coord.	If children are enrolled in any of the Coordinated Care programs, will there be any impact on their school district's ability to bill Medicaid for services/supports received in the school setting?	Services provided through LEAs are exempt from the MCO and MCCN service packages.
106	Care Coord.	If the provider (PCP or Specialty Pharmacy) is not in network with both the private insurance and the Medicaid MCO, how will the benefits be coordinated? Is there out of network benefits for members that are unable to locate a provider that is in both networks?	Clients with comprehensive third party insurance (TPL) are excluded from this program. Any other insurance available to an enrollee must be used prior to Medicaid. Medicaid is the payer of last resort regardless of whether through the fee-for-service system or the managed care system. Health plans will need to work together to coordinate services if a third party is involved.
107	Care Coord.	Does each plan have a "Care Coordinator" that will help clients coordinate their health care needs?	Yes. Each Health Plan has Care Coordinators to help assist clients coordinate their health care needs. The degree of that coordination is dependent upon the needs of the enrollee.
108	Care Coord.	Will we be paid if we see a patient that does not participate with the ACE/CCE/MCO that we participate with?	MCO and MCCN rules regarding out-of-network services vary; providers should always contact the MCO or MCCN for prior authorization before providing an out-of-network service. For ACE and CCE enrollees, if the provider is an IHC PCP, but not the patient's IHC PCP, a referral will need to be obtained and entered into IHC system from the client's PCP in order to receive payment for services rendered. If the provider is not an IHC PCP, no referral is necessary to receive payment from HFS in fee-for-service.
109	Care Coord.	How will SNF providers be notified as to what HMO and PCP a resident is enrolled with? Will this information come up when we run eligibility inquiries?	Health Plan enrollment is available through the Department's MEDI, EDI and AVRS system. All providers should check eligibility and enrollment prior to providing services.
110	Care Coord.	As a provider (pediatrician) and we are in a Cook county/DuPage region. What region and what plan we need to sign in with if we want to keep the patient`s we have. Our patient`s currently enrolled in Illinois Health Connect	Please see the Care Coordination website for the map of counties and health plans. There are also provider services contacts listed on the website. http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx

	Category	Question	Response
111	Care Coord.	I work in a practice of 33 primary care pediatric physicians. Is there a listing that we can receive of patients who have chosen each of our 33 docs as their PCP and info as to whether they'll be staying with classic Medicaid or moved to a care coordination entity?	There is no such list produced by the Department. Providers should check eligibility and health plan enrollment through MEDI, an EDI vendor or the Department's AVRS. The ACE and CCEs health plans will receive daily rosters with the names of individuals that have either selected or been assigned to them. These plans will coordinate this information with their providers. The MCOs and MCCNs may offer such information; providers should work with the health plans with whom they contract.
112	Care Coord.	Is there money available to support the administrative cost of contracting and conducting UM with the different MCO and ACEs that will be required of providers?	Not through the Department. Providers may negotiate any such payment with the health plans.
113	Care Coord.	There has been a lot of confusion around the County Care waiver ending and them coming on as an MCO. Can you talk about this?	The Cook County waiver allowed an earlier Medicaid eligibility period for ACA adults in Cook County through the Cook County Hospital and Health Services System. That waiver ended on 6/30/14. Beginning 7/1/14, clients enrolled in the waiver were enrolled in the newly created CountyCare MCCN. The CountyCare MCCN will serve SPD, FHP and ACA clients. It will operate substantially the same as all other MCOs and MCCNs.
114	Care Coord.	Previous information given by our IHC provider representative was that IHC will "stand behind" the ACEs for 18 months, then the ACE will stand alone. Is this still correct information and can you elaborate?	IHC will assist the ACEs during the first 18 months with processing provider networks and enrollment/panel rosters. When the ACE transitions to an MCO or MCCN and accepts partial risk, the health plan will operate as that type of plan and will no longer require assistance from IHC.
115	Care Coord.	Will HFS be demanding certain standards of operations for these new care entities? Meaning, will HFS state to the MCOs /ACEs/ MCCNs that they must have Saturday hours or extended hours? We understand the need for patient access but some of these demands are unrealistic, especially for smaller practices.	MCO and MCCN contracts do have access standards for appointments. ACEs and CCEs have the IHC PCP standards for appointments.

	Category	Question	Response
116	Care Coord.	You mentioned that newborns will be automatically enrolled in the mother's plan. Who is responsible for notifying the plan of the birth? Normally, our hospital sends the 2636 Record of Birth form to the caseworker. Will we still do that?	Yes, hospitals should continue to report births to the caseworker as they currently do. If the newborn is added to the case within 90 days and the mother was in an MCO or MCCN on the date of birth, the newborn will automatically be added to the health plan retroactive to the date of birth. If the newborn is added to the case after 90 days, the MCO or MCCN enrollment will still be automatic but will be prospective. It is assumed that if a hospital has an MCO or MCCCN enrollee for delivery, the hospital will also contact the health plan regarding the admission and birth. If the newborns mother is enrolled in an ACE or CCE, the mother will receive an enrollment packet from ICES to pick a health plan and PCP for newborn.
117	Covered Services	Which patients or plans are exempt from the Four Rx limit? Will all children with special needs be exempt from the 4 Rx limit, or only those in Children's CCEs? How does HFS intend to manage the 33,000+ children with special health care needs who may need more than 4 prescriptions but who aren't eligible for a CCE because of the network size limitations?	Children with special needs will have the option to enroll in a CSN CCE, ACE, MCCN or MCO, which combined have more than enough capacity for all these children in the State. Currently in the fee-for-services system, under which services for ACE and CCE enrollees are reimbursed, prescriptions for children under the age of 19 will not reject as a result of the four script policy. In addition, many of the MCOs and MCCNs do not apply the policy. Providers should always check with the health plan on specific coverage and reimbursement questions.
118	Covered Services	Some of our consumers, who have developmental disabilities and reside in Host Home CILAs, have been told by their health plans that they are required to use their pharmacy services to receive medications. It is our understanding that consumers have a choice in the pharmacy that they want to use. Our agency uses SafeDose in order to maintain compliance with Rule 116. Can you please clarify what the requirements are around CILA consumers and pharmacy services?	This initiative does not impact the requirement to comply with existing laws or rules regarding administration of medication. You should ensure your pharmaceutical company is enrolled with any MCO or MCCN in which your residents are enrolled.
119	Covered Services	Now that the state has re-instituted Adult Dental benefits, are kids staying with the All-Kids plan or are they to be a part of MCO responsibility?	Dental services are a covered service and must be provided for all health plan enrollees. MCOs are required to have a dental network and coordinate, cover and reimburse for all Medicaid

	Category	Question	Response
		How is all this working with dental Medicaid benefits? For example, if a patient picks Blue Cross as its Medicaid MCO, will that also be their network provider for dental care? How do dental services fit in? Can you please address how coordinated care impacts access to Dental services in light of the new law that lifts the SMART act changes to adult dental?	covered dental services. CCEs and ACEs will coordinate dental access for their enrollees, but the Medicaid fee-for-service program will continue to reimburse for dental services through the Department's dental administrator, DentaQuest (for the first 18 months for ACE enrollees).
120	Covered Services	Does manage care cover pregnancy and pregnancy care?	Yes.
121	Covered Services	With MCO you said they have to pick a primary care provider but can they go to local health department for their immunizations if the health dept is contracted with MCO? Do health departments have to have a referral from PCP to be able to bill for those immunizations?	Local Health Departments may contract with the MCOs to provide covered services to their enrollees. Local Health Department's should check eligibility prior to providing services to ensure they have an arrangement with the client's health plan so that they can receive reimbursement.
122	Covered Services	How will NCPAS services be obtained for children under Coordinated Care?	Nursing and Personal Care Services (NPCS) is an MCO and MCCN covered service.
123	Covered Services	How will this impact Rural Health Clinics?	Rural Health Clinics located in or near any of the mandatory regions should contract with the health plans to continue to provide services to their patients.
124	Covered Services	We understand that the MCO plans can waive "co-pays", however, I believe the real question is, isn't the provider in a SLF/SNF supposed to collect the income. (resident resource) regardless? The plans are saying no co pays, however when the insurance company gets the file from the state showing the portion due from the resident, I assume the insurance company will pay the provider less the resident liability. Could you clarify?	Use of a LTC resident's post-eligibility income is not a coinsurance. This amount, termed a "Patient Credit" is what the DHS caseworker has determined the resident is responsible for paying the facility towards their cost of care each month. Medicaid-eligible LTC residents are exempt from copayments due to their income being budgeted to pay towards their LTC costs each month. This occurs the first full month of a LTC stay. Income is not budgeted the first month of admission if the admission was after the first of the month.

	Category	Question	Response
125	Covered Services	1)Are service benefits offered by managed care entities different dependent upon Medicaid classification (i.e. TANF, ACA, SPD)? If so, does HFS require that these organizations require specific service? A particular MCO authorizes few Rule 132 services if an individual has TANF Medicaid. 2) Are CMHC's required to submit ILSR's for individuals enrolled in managed care entities? 3) Are CMHC's required to obtain authorization via the Collaborative for CST/ACT when individual is enrolled in managed care? 4) Is authorization for services required through ACE? 5) Can an individual receive behavioral health services through any provider when enrolled in an ACE?	Services are not different based on classification. The health plans are responsible for all Medicaid Covered Services under the Family Health Plan and Integrated Care Program. These two programs cover the FHP, ACA and SPD populations. Rule 132 services are a covered service. CMHCs should continue to submit service registration information on individuals through DHS. CMHCs should get prior authorization via the MCO or MCCN for CST, AST (if the health plan requires authorization). Authorization for services under an ACE or CCE should continue through the Collaborative as it is today. Individuals can receive BH services through any Medicaid enrolled provider but should coordinate that care with ACE or CCE.
126	Covered Services	As a behavioral health care provider, are we still required to register these clients with the collaborative?	All MCOs and MCCNs must provide Rule 132 services. Registration for clients through DHS is still a requirement. For MCO and MCCN enrollees, you will use the health plan's behavioral health network for access and choice.
		We are a Community Mental Health Center, are we going to continue to use Illinois Mental Health Collaborative for Access and Choice?	
		Will all the plans be required to follow Medicaid Rule 132 required documentation?	
		Are MCO's required to fund mandated rule 132 services?	
		Will Value Options still coordinate client's registrations?	

	Category	Question	Response
127	Covered Services	Orchard Village is a provider of Community Integrated Living Arrangement (CILA) services for individuals with Developmental Disabilities. Currently all of our services are paid through The Department of Developmental Disabilities as a Medicaid Waiver Program. When is the Phase 3 portion of this transformation scheduled? Will providers in this area be provided support to make this transition? All of our services have been paid through a grant from Dept. of Developmental Disabilities. From the discussion on the webinar, it appears CILA services could become a fee for service program, is this correct?	HFS has not set a date to implement Phase 3 of the Integrated Care Program. Providers and advocates of the DD community will be consulted and play a part of the design and implementation when Phase 3 discussions begin. CILA services are not going to become fee-for-service; they are included in the covered services provided by the MCOs and MCCNs.
128	Covered Services	Will the family health plans include SASS crisis services for children? What about SASS services - are these covered by the ACES/ MCOs?	The Screening, Assessment and Support Services (SASS) Program is a short-term, crisis intervention program for children and youth experiencing a psychiatric crisis and potentially requiring inpatient psychiatric hospitalization. The SASS program features a centralized intake phone line, the CARES Line, and provides face-to-face crisis assessment and stabilization supports and services to youth and families.

	Category	Question	Response
		Will the new entities pay for SASS services?	MCOs and MCCNs will not be responsible for replicating the SASS program in whole. However, there are components of the SASS program that MCOs and MCCNs will be responsible for providing, as defined by their contract. Primarily, they will be required to operate a mobile crisis response service on a 24/7 basis and ensure a face-to-face screening to all enrolled children experiencing a behavioral health crisis within 90 minutes of notification. The MCOs must ensure that all enrolled children who potentially require psychiatric inpatient hospitalization, acute care or sub-acute care are screened prior to admission for the viability of stabilization in the community, as required by the Children's Mental Health Act of 2003 (405 ILCS 49/1 et seq.). They will be required to establish a method for families to contact the MCO or MCCN (a centralized intake unit) and report episodes of crisis and in the event that the report of crisis goes to the state-funded CARES Line, ensure that the their Mobile Crisis Response System will respond to the MCO's internal intake and the states centralized intake, in an effort to stop youth from falling through the cracks. CCEs and ACEs will be required to establish operating relationships and linkage agreements with SASS until CCEs and ACEs transition to risk bearing financial arrangements and their contractual responsibilities shift to those similar of MCOs and MCCNs.
129	Covered Services	Will MCOs and MCCNs cover and pay for adult behavioral services in a free standing hospital? Will they cover both inpatient and outpatient services? Will this decision to cover behavioral health services be consistent among all the MCO's and MCCN's, or will it be up to each to decide individually?	MCOs and MCCNs may each individually determine how they will meet the psychiatric needs of their enrollees (children and adults), and their network coverage of inpatient and outpatient psychiatric services. This may include free-standing psychiatric hospitals as well as psychiatric units in general hospitals.
130	Covered Services	How do we handle these plans regarding Vaccines for Children Program? Just as if they are regular Medicaid, so use VFC vaccines? Will the VFC program remain the same?	The MCOs are required to use the VFC program. For ACE and CCE enrollees, it would be handled as it is currently.
131	Covered Services	With managed care do all plans cover pregnancy care?	Yes.

	Category	Question	Response
132	Covered Services	The State's benefits year is July 1st through June 30th and physical therapy limits are 20 per discipline. What happens if a Medicaid member has used 20 PT visits by June 30th of 2014 and is moved to a ICP plan in August which runs on a calendar year. Will the member have zero therapy benefits until January 1, 2015?	The new law, Public Act 98-0651, has eliminated the 20 therapy limit, but continues to require prior authorization in Medicaid fee-for-service, which would apply to enrollees in CCEs and ACEs for 2014 and 2015. The MCOs or MCCNs will require a new prior authorization and will apply their utilization criteria.
133	Billing	How does this affect the billing aspect of claims. Are the different groups going to be billed different is there a set pay for private physicians does the payment differ according to patient volume how does this change affect small private practices.	For the MCOs and MCCNs, providers must enter in a contractual relationship with these health plans, billing and reimbursement will be pursuant to that contractual agreement. For ACEs and CCEs, providers will continue to be reimbursed through the Department's regular Medicaid fee-for-service program (for 18 months, in the case of ACEs).
134	Billing	Please explain full-risk capitated payments and partial-risk capitated payments.	A full-risk capitated payment means that the Department pays an MCO or MCCN one set amount for each enrollee. The health plan must provide all required services for that enrollee, regardless of whether actual expenditures are more or less than the full-risk capitated payment. A partial risk capitated payments means that the Department pays an MCO or MCCN one set amount for each enrollee, but provides some sort of protection against catastrophic costs, such as a risk corridor or risk sharing above a certain dollar amount.
135	Billing	How do you envision reimbursement will be after the 3 years of transition? What kind of capitation payment and bonus payment will there be? How will it be addressed the issue of covering provider costs and margins? Please explain about payment to providers particularly pediatricians through ACE after 18 months when fee for service will be stopped as I understood. What means partial and full capitation system at ACE after 18 mo.	Within 18 months to 3 years it is anticipated that all ACEs will be operating on a risk basis. Capitation and bonus payments for enrollees in these plans will be pursuant to the provider/health plan contract that will be negotiated by the parties.
136	Billing	Will our pricing change?	Providers and the MCOs and MCCNs will negotiate rates in their contract. Reimbursement for enrollees in ACEs (for 18 months) and CCEs will continue through the Medicaid fee-for-service program at the Medicaid rate.

	Category	Question	Response
137	Billing	Can you speak more about how ACEs will pay organizations?	ACEs will be coordinating the care for their enrollees. They are not responsible for claims payment. Claims for ACE enrollees will continue to be reimbursed through the regular Medicaid fee-for-service program for first 18 months.
138	Billing	Can hospital providers expect future claims to be paid quicker or will the state delay capitation payments to Medicaid managed care entities due to cash flow considerations?	Historically, most MCOs have made payments quicker than HFS has made to non-expedited providers. Providers in ACE's and CCEs will continue to bill through HFS' regular Medicaid fee-for-service (for 18 months, in the case of ACEs).
139	Billing	How supportive will the Department be in making certain the HMO's are paying timely? Will you enforce your rules?	The MCOs have timely payment provisions in their contracts; they are required to pay interest on any late payments just as the Department is. The Department does monitor their timeliness of payment. Currently they are reimbursing providers much faster than the Department's fee-for-service reimbursement.
140	Billing	For new enrollees in the expansion that reside in a nursing home and are enrolled in hospice - how will the Hospice bill Room and Board?	Hospice will bill the health plan for the residential portion. To notify the health plan of the hospice enrollment, hospice providers should complete a standardized Medicaid Notice of Election Form for hospice clients. This form is submitted to both HFS and the health plan in which the member is enrolled.
141	Billing	For Hospice providers, will all of these plans cover Hospice patient? How will these plans cover dual eligible patients? How will they manage and pay for room and board services at Nursing homes? Are the MCO's & ACE's going to pay room and board under hospice, or do hospices continue to bill the state for room & board.	MCOs and MCCNs will cover hospice services and nursing facility services, including room and board. The only program that includes enrollment of dually eligible enrollees at this time is the MMAI demonstration. For enrollees in the MMAI demonstration, as a provider, if a beneficiary elects hospice, you would bill Medicare FFS for the Medicare hospice services and hospice drugs. If the enrollee resides in a NF, the health plan will be responsible for the "room and board" component. For ACE and CCE enrollees, providers will continue to bill and be reimbursed through the HFS Medicaid fee-for-service program (for 18 months, in the cases of ACEs).
142	Billing	I notice that in previous communication, ACE and CCE providers will continue to bill the state for services provided and will follow the PA process currently in place at the state as well. Questions: 1. Will the Pharmacy Benefit also follow this same procedure? 2) Will the PA for certain pharmacy products be obtained from the state? 3) Will the PA criteria be set by the state or the ACE and CCE plans?	Pharmacies should continue to seek prior authorization and reimbursement as they currently do under the HFS regular Medicaid fee-for-services program. All HFS policies and procedures still apply. The ACE and CCE plans will not review or approve prior authorization for services.

	Category	Question	Response
143	Billing	Will PCPs continue to receive yearly incentive payments for providing complete preventive care to children who select them as their PCP in an ACE? In a MCO?	MCOs and MCCNs may include in their provider contracts a performance bonus, which is negotiated between the health plan and the providers. PCPs will continue to receive the yearly EPSDT bonus payment for providing complete preventive care to children who select them as their PCP in all health plans: CCEs, ACEs, MCCNs and MCOs. In addition, PCPs participating in an ACE or CCE network will continue to qualify for the annual IHC Bonus Payment for High Performance Program.
144	Billing	For Managed care, we are paid part of our rate from the managed care company and some from Public aid. Will this process continue?	All Medicaid behavioral health services will be covered and funded through MCOs and MCCNs for their enrollees.
	Billing	Will the Department allow out-of-network claims during the transition, and for what period of time? What options are there for PCPs who do not join an MCE? Would the Department consider a reduced FFS fee schedule for these providers.	Once a client is enrolled in an MCO or MCCN, the Department will not reimburse for covered services through the fee-for-service system. These health plans are required to allow an enrollee to continue care with an out-of-network provider for the first 90 days if under a current course of treatment or in the third trimester of pregnancy. The Department will not consider a reduced FFS fee schedule.
145	Billing	If we are not yet enrolled with a managed care, will be still receive our HFS rate from them and add-ons from HFS? We also need to make sure that the Managed care companies know our rates (including the disproportionate share amount) so that we are paid at the correct rates by both managed care and public aid. Will this be supplied to them by HFS?	HFS supplies the DRG auto-calculation sheet and per-diem rate sheet which includes the MPA and MHVA rates to the MCOs annually. Disproportionate share payments are paid and will continue to be paid by HFS based off of the MCOs encounter claims.
146	Billing	Is there a mechanism for payment for individuals who live on the border of the state, who enroll in another state's plan, but come to us for care? Would this be considered out of network?	If the Health Plan has not contracted with the out-of-state provider, it would be considered out of network. Health plans may negotiate rates for out-of-network services.
147	Billing	What will happen with DASA? Will we be billing DASA or the HMO?	MCOs are responsible to cover Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390, 77 Ill. Admin. Code Part 2090, Day treatment (residential) and Day treatment (detox).
148	Billing	What happens to the Rural Health Clinic encounter rate?	Rural Health Clinics providing services for ACE and CCE enrollees will continue to bill the Department as they currently do under the HFS regular Medicaid fee-for-service program (in the case of ACE's, for 18 months). Rural Health Clinics should enroll with any health plans operating in their area to ensure they can continue to serve those enrollees.

	Category	Question	Response
149	Billing	Due to the application backlog, what happens to pending applications that have several months due to facility when application is approved? Does Medicaid paid us directly for those months and the MCO pay forward?	Yes, any retroactive eligibility period in this situation will be reimbursed through the HFS regular Medicaid fee-for-service program. Enrollment in the health plans is prospective.
150	Billing	Will the managed care companies still pay PCP monthly payments for every patient who has our Dr as a PCP?	The PCP monthly payment has been included in the MCO and MCCN capitation payments. It is up to the MCO and MCCN to negotiate payment with their contracted providers. PCPs in an ACE or CCE will continue to receive the IHC monthly care management fee for each member enrolled with the PCP for care coordination.
151	Billing	If a complex child chooses an ACE instead of a CCE, will the ACE receive the Care Coordination fee of a CCE rather than the $9 PMPM as a ACE?	No.
152	Billing	Will speech evaluation codes still need to be billed in 15 minute increments?	Billing for all ACE (for 18 months) and CCE enrollees will be exactly the same as it is under the current Medicaid fee-for-service system. Providers should receive information from any MCOs or MCCNs for whom they are providing service on billing requirements.
153	Billing	Effective July 1, if a Medicaid patient enrolled in any of the managed care Health Plans presents to the emergency room at either of our two hospitals (St. Mary's Hospital in Marion County in Centralia or Good Samaritan Regional Health Center in Jefferson County in Mt. Vernon), will these ER services be reimbursed by Medicaid, and if so, at what rate – Medicaid fee-for-service? If the patient who presented through the ER subsequently is admitted to the hospital as an inpatient, same question – is the inpatient stay reimbursable and at what rate?	Emergency services are direct access services in all Medicaid programs. For ACE's and CCE's, hospitals will continue to bill HFS regular Medicaid fee-for service for these services (in the case of ACEs, for the first 18 months), and will notify the ACE or CCE of the service provided to the enrollee to ensure appropriate coordination of care and discharge planning. For MCOs and MCCNs, the hospital will bill the health plan, who is required to pay at least the Medicaid fee-for-service rate. Admission to a hospital for an MCO or MCCN enrollee needs to be pursuant to the contract between the hospital and the health plan, or if out of network, then it must be prior authorized by the health plan prior to admission. Currently, Marion County and Jefferson County are not in mandatory managed care regions.
154	MEDI	How soon after a patient enrolls in a plan will their plan information be available on MEDI? If providers would like to inquire which MCE is going to be assigned their patients, which bureau within the Department should they contact?	Health plan information will be available on MEDI as soon as the enrollment is reflected in the Department's system. It is this enrollment that initiates the health plan to send the information to their enrollee, so the health plan information should always be on MEDI prior to them receiving information from a health plan.

	Category	Question	Response
155	MEDI	How soon does MEDI update when the client changes plans?	Once the client's health plan change is received from the Illinois Client Enrollment Services in the HFS MMIS system, MEDI is updated immediately.
156	MEDI	The Medi system isn't always accurate. The Medi system would say that the client has County Care and then when you call County Care they say their system hasn't updated the information. If a facility enrolls a client based upon the Medi system it isn't a reliable source.	MEDI is the source for the expansion.
157	MMAI	Does the mailing scheduled dated 6/23/14 include Duals in MMAI? The initial schedule noted this to occur over 6 months and we were trying to understand how the rollout would occur for MMAI.	The mailing schedule dated 6/23/14 is not for the MMAI program, it is for the FHP/ACA clients whose enrollment is just beginning. The MMAI program began mailing in January for clients in the community and continues to date. The earliest HFS anticipates sending the first batch of LTSS enrollment announcements for the MMAI program will be in September 2014, with the first voluntary enrollments effective October 1st.
		When will a letter be sent to residents in a nursing home telling them how to enroll in the MMAI?	
		We are a dialysis provider. We are looking for information on the timeline that our patients will be contacted for MMAI across the various counties. We have many eligible Dual patients in most of the designated MMAI counties and have heard little to date from our patients.	
		We are a long term care facility. It was our understanding that a dual eligible could maintain their traditional Med A B & D benefits, but would (eventually) have to be enrolled in a plan for their Medicaid benefits. However, this is contrary to what the enrollment broker is telling our clients - they are saying either opt in for all (both Medicaid and Medicare) or opt out of all.	
158	MMAI	Does MMP pertain to the dual eligible where MMAI is for Medicaid only? What is the actual acronym that we need to look for when we run the resident through the MEDI system to verify what benefits they will receive?	MMP stands for Medicare/Medicaid Plan, which are the MCOs that participate in the MMAI demonstration. There is no specific acronym that describes the benefits package of the client. However, any client enrolled in one of the health plans is eligible for the full Medicaid benefit package. Clients enrolled in the MMAI demonstration are eligible for Medicare and Medicaid benefits.

	Category	Question	Response
159	MMAI	Currently, we have examples of the DUAL eligible plans that the Medicare and Medicaid HMO product paid and then Medicaid fee for service paid in addition. Is your system corrected to flag these eligible patients?	The Department's system should not allow fee-for-service claims to be paid for MMAI covered services. The Department will contact you to obtain specific examples to research.
160	MMAI	Can you briefly touch on prescription drug copay ranges for the Dual Eligible population? What can a dual eligible anticipate paying for prescription drugs, minimum and maximum?	Medicare Part D establishes the copayment ranges; Illinois Medicaid does not. Illinois Medicaid does not provide any coverage for drugs for Medicare Part D eligible participants when those drugs are covered under Part D. Therefore, the participant would be responsible for the full copayment established under Medicare Part D. All duals are eligible for low income subsidy. In 2014, the maximum co-pay for which a low-income subsidy eligible individual would be responsible is $2.55 for each generic/$6.35 for each brand-name covered drug. This information is available at: http://www.medicare.gov/your-medicare-costs/help-paying-costs/save-on-drug-costs/save-on-drug-costs.html
161	MMAI	For the Duals Demo, it appears eligible seniors will be enrolled in a Care Coordination plan. How does this affect their Medicare benefits? Does it knock them off of their Medicare Advantage plan?	An MMAI enrollment will cause a client to be disenrolled from a Medicare Advantage plan. However, the Department's intent is to leave MMAI eligible clients in their MA plan and not cause a disruption in the plan/client relationship. Our ability to not enroll MA plan clients is contingent upon the MA plan enrollment information being reflected in the HFS recipient database. HFS exchanges a weekly file with federal CMS that contains information about dual eligible clients, including any MA plan enrollments. Occasionally, an MA plan enrollee will be inadvertently enrolled in an MMAI due to timing issues (MA plan enrollment isn't reflected on file prior to the passive enrollment occurring) or matching issues (client's name, SSN and DOB are not similar enough on the federal and state systems to constitute a match).

	Category	Question	Response
162	MMAI	Will MMAI enrollment remain optional and will dual eligibles be able to continue to opt out? Our facility has nearly 300 dual eligibles but so far we have only received letters of notification for only about a dozen of these residents with information that they are eligible to enroll in MMAI. All of those having received notification are in CLF facilities. All of the others, in ICF, SNF and CILA facilities have not received notification. Can we expect to receive notification for these dual eligibles and, if so, when?	MMAI enrollment will remain optional. When the Department implements the Managed Long Term Supports & Services (MLTSS) program, any dual eligible client that opts out of MMAI will be required to enroll in the MLTSS program to receive their Medicaid benefits. The Medicaid services that will be provided by the health plans include their LTSS (nursing facility or Home and Community Based waiver services), and their transportation and behavioral health services that are not covered by Medicare. The same MCOs participating in the MMAI demonstration will participate in this MLTSS program. Any clients that have not yet received their MMAI enrollment material should expect to receive it in September or October. Clients receiving developmental disability institutional services or who participate in the HCBS waiver for Adults with DD are excluded from enrollment. They will not receive MMAI enrollment material as long as the DD information is updated and reflected on HFS' system.
163	MMAI	Why can't opting out of MMAI be done online?	The Memorandum of Understanding with Federal CMS for the demonstration does not allow MMAI opt-outs to be processed on-line. The Department wants the opportunity to educate clients on the benefits of care coordination so the clients can make an informed choice.
164	MMAI	I am running into issues with clients who have received their letters and are choosing to opt out of the MMAI. However, their Medicare Part D is also being cancelled; even prior to the date in which they have to choose.	This is an issue with the timing of notices, not actual Part D coverage. MMAI enrollees will continue to have Part D coverage until the effective date of enrollment in an MMAI health plan.
165	MMAI	Does a member have the option to return to what is referred to as "regular Medicare" once they have been auto-enrolled in MMAI? Can dual enrollees (MMAI) opt out of this initiative?	A client may opt-out of MMAI at any time, and return to their previous Medicare delivery system whether that was regular Medicare or a Medicare Advantage plan. If the client is residing in a nursing facility or receiving HCBS waiver services, they will be required to join the MLTSS program and choose a health plan to coordinate their LTSS. If they are not in a nursing facility or receiving HCBS waiver services, they will continue to receive their Medicaid services that are not covered by Medicare through the Department's regular fee-for-service system.
166	MMAI	I have group homes for the Developmentally disabled Adults and I was wondering if the Individual has both Medicaid and Medicare, dual eligible, do these Individuals have to be enrolled in this program.	The only Department program currently available for dual eligible clients is the MMAI demonstration. Clients receiving developmental disability institutional services or who participate in the HCBS waiver for Adults with Developmental Disabilities are excluded from enrollment.

	Category	Question	Response
167	MMAI	My questions are regarding the MMAI programs. Do they all have to follow Medicare's fee schedule? When will patient's be restricted to an open-enrollment, instead of being able to jump from one plan to another each month? Finally, do the plans follow Medicare's coding restrictions? For example, do the MMAI programs accept consult CPT codes (99253 - 99255) which at this time Medicare does not allow those CPT codes?	Reimbursement rates in the MMAI program are negotiated between the MMAI health plans and the providers. The demonstration does not allow for a lock-in. Questions regarding billing requirements of the health plans should be directed to the health plan.
168	MMAI	MMAI - We had an resident in LTC facility approved for Medicaid and immediately enrolled in a MMAI plan before she had a chance to choose. – It's on MEDI and Medicare eligibility screens listed as her plan. Then she receives a letter saying she has two months to choose a plan. AFTER HFS has already enrolled her in a plan. So how can it be that she is already enrolled when she is supposed to be able to choose. This has happened to 3 or our residents. - Also our residents have selected physicians in the MMAI plans but then the physicians come back and say they are not accepting new patients. What are we supposed to do about that?	Clients have 60 days to make a choice. The auto-assignment algorithm is run at the beginning of the 60 day period in order to send information to the health plan so that they can send member materials to the enrollee prior to the start of the coverage. Receipt of this information from the health plan in no way cuts short the 60 days the client has to make a choice.
169	MMAI	Some of our providers are in an MMAI network through their IPA/PHO affiliations. Does this put them in network for all MMAI members or only those who are assigned a PCP affiliated with the relevant IPA/PHO?	That would depend on what the provider's contract with the IPA/PHO states regarding this situation.

	Category	Question	Response
170	MMAI	Why is the passive enrollment process different for Medicare Advantage beneficiaries v. Original Medicare beneficiaries? - why are some MA participants allowed to forgo the passive enrollment, whereas the Original Medicare benes are being passively enrolled?	If a dual eligible client in the demonstration area is participating in traditional Medicare, they will be passively enrolled into an MMAI plan if they do not choose one or do not choose to opt out of MMAI. If a dual eligible client in the demonstration area is enrolled in a Medicare Advantage Plan that also participates in MMAI, they will be passively enrolled into the same health plan in MMAI. If a dual eligible client in the demonstration area is enrolled in a Medicare Advantage Plan that does not participate in MMAI, they will not be passively enrolled into an MMAI plan, but may choose to voluntarily enroll. This group was excluded from passive enrollment because they have an MA Plan not participating in MMAI.
171	MMAI	I was told by HFS staff that people who are on a DD waiver are NOT being passively enrolled into MMAI at all at this point. (So those individuals would not be in an MMAI plan for medical or LTSS services for now.) It sounds like that may not be true?	Dual eligible clients participating in the DD Home and Community Based waiver are not eligible to participate in the MMAI demonstration.
172	MMAI	For MMAI beneficiaries who are receiving LTSS, how does this affect behavioral health services? I had read that benes can opt out of MMAI for health care, but must choose a managed care plan for their LTSS, transportation, and behavioral health services.	The Department applied and was granted a 1915b waiver from the Centers for Medicare and Medicaid Services (Federal CMS). This waiver allows the Department to require clients who are receiving long term supports and services that opt out of the MMAI demonstration, to enroll in an MCO for their Medicaid services. The Medicaid services that will be provided by the health plans include their LTSS (nursing facility or Home and Community Based waiver services), and their transportation and behavioral health services that are not covered by Medicare. The same MCOs participating in the MMAI demonstration will participate in this Managed Long Term Supports and Services (MLTSS) program.

	Category	Question	Response
173	MMAI	I have clients in MH Outpatient services who are Medicare/Medicaid covered. These clients are being sent letters to choose a MMAI plan that is in our area. If they do not opt out, they are assigned a managed care plan (Molina) in our area. I have assisted clients in opting out. However, their Medicare Part D coverage is being cancelled even prior to the end date. They must then reapply for Medicare Part D. This is going to cause dozens of our clients who do not understand this process to end up with insurance coverage they did not choose and medications that will not be paid for under their new insurance.	Be assured that clients are not losing their Medicare Part D coverage and there is no gap in coverage for pharmacy as clients select health plans or opt-out of MMAI. When a client enrolls in MMAI, the health plan assumes responsibility for all prescription benefits. Upon enrollment in an MMAI plan, an indicator is sent to CMS. The Part D program is sending out its cancellation notice for the regular Part D program before the health plan is sending out their welcome packet explaining that the client's prescription benefit will now be obtained through the health plan. This problem has been brought to the attention of CMS, and the Department has changed some operational functions to have the MCOs send their information sooner. This appears to have alleviated most issues.
		MMAI customer no longer has Med D, correct?	
174	MMAI	For MMAI health plans, are they required to reimburse the hospitals for bad debt or is this an option since hospitals cannot include MMAI patients on their Medicare cost report.	Bad debt was considered and is included in the capitation rate paid to the MCOs. Hospitals should consider this when negotiating rates with MCOs.
175	MMAI	Our Cook County 60634 nursing home has 18 MMAI eligible residents of which we have received only two "letters". Why have we not received letters for all 18 residents and when will we receive the other 16 letters? Per your statement, "by august 1st all nursing homes will receive their letters". Question: then why have we already received 2 letters? How did you determine to send these 2 letters? How did you decide not to send the other 16?	The roll-out for ICP and MMAI for clients residing in nursing facilities has not yet begun. It is likely that any of your residents that received an enrollment packet may not be coded correctly in the HFS system. However all of your Medicaid residents should be receiving enrollment packets this fall.
176	MMAI	We have had some SPD residents who live in our skilled nursing facility enrolled in MMAI. Our facility is not listed in the MMAI. Is this just for the dual eligible period? If this resident is on Medicare, will they have to go to another facility that is in their MMAI?	Providers are encouraged to enter into contracts with all MMAI plans in order to maintain current patient/provider relationships.

	Category	Question	Response
177	MMAI	Several of my clients have received enrollment letters, allowing them to choose between 2 insurance companies. Prior to the deadline on the letter, 2 clients were enrolled in companies that their primary care providers were not a part of, automatically. The letter stated they had until the end of May to pick, but mid-May they received enrollment information from a company, without doing anything on their own. I assisted them in switching to the other company. However, this has created a lapse in their coverage for some reason. For example, 1 individual was told her Health Alliance would start on 7/1, but in June, when she went to receive her prescriptions, she was told that her previous coverage (Medicaid/Medicare) terminated on 5/31. This creates a month's time where she has no coverage. How is this being addressed and how as a case manager can I be of assistance to my clients when and if this occurs.	There should never be a lapse in Medicare or Medicaid coverage due to enrollment or disenrollment in the MMAI program. Usually the confusion stems from the timing of the notices that the client receives. CMS requires the Department to report initial auto-assignment and requires the MMAI health plans to send something to the client 30 days before the effective date of enrollment. In addition, the Medicare system and the Medicaid system can sometimes become out of sync. The Department can work these issues on an individual basis.
178	MMAI	For MMAI, I thought that clients would be put in to a plan passively (if they did not choose one quickly enough) and that they could then OPT OUT. Today it sounded like you described this as an OPT IN plan. Please clarify if the MMAI program is an OPT IN (I am only in it if I choose it) or an OPT OUT plan (you will enroll me and I will have to disenroll if I do not want this)?	The webcast was in regard to FHP/ACA expansion, not the MMAI program. FHP and ACA members will be locked into a health plan for 1 year. Clients may opt out of the MMAI demonstration at any time.
179	MMAI	It has been stated that the clients will be "locked in" for a year from their enrollment date, however I was under the impression that with MMAI the clients will be able to change the Health Plan from one MMAI provider to another on a monthly basis, should the client choose to do so, is this correct? This presentation does not apply to dual eligibles (have both MED A/B and MEDICAID), correct? We understood, D/E could switch plans at any time and are not "locked in" at any point during the year.	The presentation did not apply to dual eligible clients. In the MMAI demonstration, clients can opt-out or enroll with an MCO in the demonstration at any time. This fall, those dual eligible clients receiving long term supports and services that opt out of MMAI will be required to enroll in an MCO or MCCN to manage their Medicaid services.

	Category	Question	Response
180	Network & Provider Enrollment	I work in a Skilled Nursing Facility and a family member asked me in regards to the Primary Care Physician that was assigned by their Integrated Care Program. They have had the same doctor for many years and didn't want to change their doctor. Most of the time this doctor that they've already had for years, happens to be our medical director of the facility. I told them I had not heard that they needed to stop seeing their doctor. Is this true? Will this cause issues? What exactly is the job of the PCP that is assigned by these ICP's?	An individual eligible for ICP will receive an enrollment packet from the ICES if they are required to select a health plan and PCP. A PCP will be part of the client's care team and will coordinate or provide the care needed by the client. If a provider, including the medical director, would like to continue seeing the resident, he/she should enroll with the MCO or MCCN.
181	Network & Provider Enrollment	I work for a pediatric office, HFS keeps saying clients need to enroll with a program, HOW can clients enroll with their physician IF that physician hasn't filled out an application??	If a physician does not join any of the Medicaid health plans, an enrollee will need to select a different primary care physician enrolled with a participating health plan.
182	Network & Provider Enrollment	Do we know which of the MCOs and related organizations around the state will have their mental health and/or substance use disorder services contracted out to a behavioral health entity? If so – can the contact information for these be shared.	Yes, the Department will post their Behavioral Health Subcontractors to the website.
183	Network & Provider Enrollment	We are enrolled with Illinois Health Connect and I do not understand what will happen to them? Will that program dissolve? My understanding is that there will no longer be any monthly incentive payments or bonus payments. Is that true? Thank you for clarification.	Individuals in IHC in mandatory counties will need to enroll in an MCO, MCCN, ACE and/or CCE. Providers participating in an ACE or CCE will continue to receive the monthly IHC care coordination fee and will continue to qualify for the IHC bonus Program.

	Category	Question	Response
184	Network & Provider Enrollment	We are a business that has children and adults from IL placed at our facilities (67D-CLF & CCI/RTC). We can't have them in the Managed Care while they are here because IL Managed Care won't work in WI. So it makes their only insurance invalid for everything, even for medication. They are placed here by IL counties, DHM-ICG, DHS and IL school systems. They are still an IL resident, not a WI resident, due to IL placing them and paying for their cost of care while in our facility. We need a way to get the residents from IL out of Managed Care while they are at our facilities. So far I haven't found a way, after numerous calls, when this first rolled out in Cook County.	HFS would need to understand more about why you believe an MCO or MCCN could not pay for services rendered in Wisconsin. These health plan networks are not limited to Illinois providers.
185	Network & Provider Enrollment	How will HFS know which ACE/MCO I am a member of –do I have to tell my patients or will it be listed accurately on the enrollment letters? Same issue of quality assurance as noted in #3.	Since participation by a provider in an ACE, CCE or MCO is a voluntary contractual relationship between the provider and the entity, HFS has no knowledge of the participation of the provider apart from the provider network files that the ACE, CCE or MCO is required to submit to ICES. It is up to providers and the entities to perform quality control on the files they submit to ICES. HFS does not have the information needed to conduct quality control. Letters to patients from ICES do not include provider directories, although this information is available on the ICES website. Providers should use the HFS template to inform patients of the plans with which they participate.
186	Network & Provider Enrollment	I would like to clarify that I understood this correctly: When an MCO and MCCN plan says "Full risk" or "partial risk" capitated plans, the financial risk is not to the provider. They will still be paid based on the contract and services they provide? Or are the providers financially at risk for non-payment by these plans?	The MCO and MCCN contracts with the Department contain the risk, meaning that the health plan agrees to provide all of the covered services required for the amount of the capitation payment. There are no additional payments from the Department. The MCOs and MCCNs may contract with their providers of service on a fee-for-service or capitated basis. A capitated basis would then put some risk on the provider, depending on the terms of the contract.
187	Network & Provider Enrollment	You mentioned early that emergency services were exempt from enrolling. Is this true? Will specialists need to enroll in the health plans even though they are only taking patients as referrals?	Emergency Services are direct access services. Specialists are encouraged to work with the various health plans as they build and expand their networks to increase access to care for clients.

	Category	Question	Response
188	Network & Provider Enrollment	How does a substance abuse provider who is currently Medicaid certified get to be in the provider network?	Substance abuse providers, as all Medicaid providers, need to sign contracts with the health plans. The list of health plan contacts for providers is on the Department's website at the link below under the heading "Care Coordination Roll Out Plan" http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx
189	Network & Provider Enrollment	When we join a Family Health Plan, will our panel have to be open to all patients and for how long? Will we be able to close our panel?	Providers should negotiate any panel restrictions with the MCOs and MCCNs with whom they enter into contracts. ACE and CCE PCPs will not have the option to restrict their panels to existing patients only. Panel capacity shall be determined with each plan and shall not exceed 1,800 per PCP across all ACE and CCE health plans. Panel capacity is a required field on the file that is necessary to list a PCP in a health plan. The ICES will not assign in excess of this capacity.
		How will the CEB know that a doctor/provider has reached their maximum enrollment	
		Who do we contact to limit enrollment for MCO, MCCN, ACE, and CSN and CCE rosters? HFS or the MCO or MCCN directly?	
		If we enroll in these managed care plans are we required to take everyone or can we limit the number we service?	
190	Network & Provider Enrollment	If the auto-algorithm cannot locate a preferred PCP within 30 miles for a patient (urban) or 60 miles (rural), will the patient have the choice of not joining and just continue with FFS/ PCCM?	HFS reviews these individuals prior to enrolling them to understand why there is no provider in the area. They are not exempt from managed care.
191	Network & Provider Enrollment	How do the physicians learn about the different managed care plans and sign up to participate?	All Medicaid providers need to sign contracts with the health plans to continue to provide services to their patients receiving Medicaid. A map of health plans participating by county, and the list of health plan contacts for providers is on the Department's website at the link below under the heading "Care Coordination Roll Out Plan" http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx There is no link or website to enroll providers with a health plan. Providers must contact each plan directly and their provider representative will work with you. Requirements and payment rates are to be negotiated between the parties.
		I am a provider. This video morphed to being aimed at clients instead of at providers. I am looking at what plans are available for me to choose, or to recommend my patients to choose, and I HAVE GOTTEN NO INFORMATION ON WHAT each network requires of or pays to a provider.	
		We have called and e-mailed most of those health plans and we are not getting anywhere. No one is calling us back to let us know how to enroll in the network.	
		I have tried to reach out to one of the plans in our area, but have not heard anything from them. How long before we should be hearing from them?	

	Category	Question	Response
		Are non-emergency ambulance transports required to enroll in multiple networks for hospital to hospital transports? An example is a local hospital in Central Illinois Region transport to a critical care access hospital in the Cook County Region?	
		Is there a requirement from the state that MCO, CCE, or ACE, will accept any provider into their network, given that provider is appropriately certified and or licensed, and in the geographical region?	
		It appears that the hospital, Northwest Community Hospital in Arlington Heights, does not belong to any of the ACEs plans or any other entities. A great majority of my patients are being treated at this hospital if needed. Is it possible to inquire whether they will become a part of any ACE, etc.?	
		Which providers will be able to join the network? Are the programs chosen who will be in network? and who will not?	
		Can you provide the exact link for the page where we can go on to enroll our providers for the plans please.	
		Is there a live person/representative that can help providers with region / network choices?	
		Can an ACE insist that all a provider's patients—HFS as well as commercial—join its organization.	No. By definition in state law, an ACE is an entity created solely to provide Medicaid services to Medicaid clients.
192	Network & Provider Enrollment	Our office is a pediatric office. We refer our patients to the Children's hospital in St. Louis. What happens if the hospital is not a provider? Or referring a patient to a specialist across the river in Missouri? Same situation.	Health plans are required to have pediatric hospitals in their network. If a service in a pediatric hospital is medically necessary, the MCO is required to provide it, either in-network, or if unavailable, then out-of-network. If out-of-network the MCO would negotiate a rate with the hospital for that enrollee. Providers should work with their health plan in this situation.
193	Network & Provider Enrollment	Due to sluggish reimbursement many physicians are choosing not to be involved with treating Medicaid patients. What is going to happen to engage qualified MDs to participate and improve reimbursement?	The MCOs are reimbursed on a capitated basis by the Department. The MCOs are required to have an adequate network to ensure access and contract with various providers to do so. The MCOs have the freedom to negotiate rates, which may be higher than Medicaid fee-for-service, with providers to ensure their networks are adequate. They may also offer performance bonuses in addition to service reimbursement. PCPs in ACEs and CCEs will continue to receive the monthly IHC care coordination fee and will continue to qualify for the IHC bonus program.

	Category	Question	Response
194	Network & Provider Enrollment	When you refer to providers needing to enroll as a managed care provider, does this include community based agencies that are funded through DHS-DDD who provide day program and/or residential services to adults who have an intellectual disability?	DD providers providing DD-only services do not need to enroll with the MCOs at this time. If that provider is providing any other service under another waiver (TBI, HIV, PD, Aging), they should contract with the health plans now.
195	Network & Provider Enrollment	We are the behavioral health care provider in Cass County. What networks or plans do we need to join or be part of to serve Medicaid clients as we do now? Your map shows several accountable care entities.	Cass County is not in a mandatory managed care region, but it does border several counties in the Central Illinois mandatory region. Health Plans participating in Cass County are the Illinois Partnership for Health (an ACE), and Illinois Health Connect, the Department's Primary Care Case Management (PCCM) fee-for-service program.
196	Network & Provider Enrollment	My PCP clients are being heavily recruited by ACEs but not at all by insurers. If independent physicians enroll in an ACE, what happens if the ACE cuts the capitation payments such that the independent doctors drop out. Will the patients be reassigned to other practitioners such as those employed by the sponsoring ACE? Are there safeguards in place to prevent an ACE from simply signing up independent PCPs and then dropping them (or drastically cutting payments) later in favor of their own physician employees? What is their alternative?	During the first 18 months, physicians in the ACE will continue to be paid standard HFS Medicaid fee-for-service rates. In month 19, HFS will pay capitation rates to the ACEs. The payments that physicians receive during months 19 and beyond are a negotiation between the ACE and its contracted physicians – employed or independent. These are competitive situations that all independent physicians will have to develop strategies to address. There are no safeguards other than what the marketplace provides. If a physician drops out of an ACE for any reason during the lock-in period, the patient will be reassigned to another PCP within the same ACE. Patients also have the option to choose a different plan during the first 90 days of enrollment. They will have the option to choose a different plan during their annual choice enrollment period if they wish to follow their existing physician to a new plan. Independent physicians may choose to contract with several ACEs and MCOs in their service area so that they are in the network of more than one health plan and can continue to be a PCP choice for their clients.
197	Network & Provider Enrollment	Our office currently services children under the All Kids & Public Aid most of which are special needs but some that are not. How will all of this affect them? We are an independent private dental office. Please be specific, i.e.: 1) Will our office need to join the various networks in order to continue providing services to our current and possibly new clients? 2) If the office chooses not to join any of the networks does that mean we will have to stop seeing these clients?	It is likely your patients will enroll in various health plans, so the more health plans that you join the more likely you are to be able to maintain your patient relationships. This is particularly true for the MCOs, since they will be responsible for payment of claims for their enrollees. ACE and CCEs referral requirements will operate as the process does today in the regular HFS Medicaid fee-for-service program (for 18 months, in the case of ACEs). Providers should always check MEDI for eligibility and health plan enrollment prior to providing services. If your patient is enrolled in an MCO which whom you do not have a relationship, you should always seek prior authorization from that MCO prior to

	Category	Question	Response
		Some general questions regarding oral health/dentistry: Should the providers of school based dental programs sign up with ALL networks? Should all dental providers sign up for all networks (that are regional)? Who will they bill for the services... each network or the state for children who are currently on Medicaid?	providing services. The Department, through DentaQuest, will not pay dental claims for MCO enrollees.
		We are a dental school in The Metro East mandatory area. How should claims for dental treatment be submitted in the interim period until we are signed up with the plans in our area?	
198	Network & Provider Enrollment	Can you please address what is being done in the Springfield area to get the Springfield Clinic to sign on with both Molina and Health Alliance and not just Health Alliance? We have had several residents that want to sign with Molina but their Doctors are with the Springfield Clinic. They feel like their right to choose is being taken away.	The Department cannot force a provider to enroll with any specific health plan. Residents should make their preferences known to their providers.
199	Network & Provider Enrollment	For us PCPs, do we need to update our contract with these insurances? How do we know if we are a participating provider?	Providers that are unsure of the contract status should contact the health plan to confirm they are part of the network for FHP/ACA and that all information on file is still current.
	Network & Provider Enrollment	When does the Department envision that all the state's geographic areas will have adequate provider networks? Will the PCCM undergird the transition in these challenging areas?	The Department and its External Quality Review Organization (EQRO) review the network of all health plans in a geographic area before approving the roll-out in that area to begin.
200	Network & Provider Enrollment	We have had two Health Plans available to our disabled pregnant women in Kankakee county for the past couple of years: Aetna and Illini. However, one of these plans remains unsuccessful in contracting a local prenatal provider. The nearest contracted provider is approx. 60-70 miles away. Subsequently, a trend has developed in that pregnant women enrolled in this particular plan are utilizing the two emergency rooms in our area for primary care...despite being educated not to do so. So cost factors have increased for these women despite the goal of saving costs. Has this been addressed to prevent this from happening when everyone will be enrolled in a plan?	There are now more health plans participating in all managed care programs in Kankakee. The health plans are required to ensure access to care, and must provide such out-of-network if it is not available in-network. The Department routinely monitors complaints regarding the health plans. Specific client issues such as the trend noted should be reported to the health plan and the Department with specifics so that appropriate monitoring and compliance actions can be taken.

	Category	Question	Response
201	Network & Provider Enrollment	When potential patients call and want to choose as their PCP and ask for our Medicaid number....is that our Medicaid provider# or NPI. Just want to clarify which number links us to them as their PCP.	Your HFS Medicaid provider number would be the best number to ensure they are choosing the correct PCP. May want to ensure the client has the correct spelling of the PCPs name and correct address information too, to help expedite the enrollment process for the client.
202	Network & Provider Enrollment	If our providers are currently contracted with the insurance, etc. BCBS, Aetna, Humana do we have to have separate contracts for this population?	That would depend on if your current contracts included these specific populations. If they do not, the current contracts would need amended to add them or you would need a new contract. That is between the provider and the MCOs.
203	Network & Provider Enrollment	If Illinois Health Connect "goes away," how will advanced practice nurses, especially nurse practitioners and certified nurse midwives, be able to enroll as a provider for any of the plans? In other words, are there any restrictions in any of these plans that would preclude these APNs from enrolling as primary care providers?	No.
204	Network & Provider Enrollment	What do we do if our credentialing with MCOs is not complete, it is in process could take 60 days? We are a FQHC and have significant issues with credentialing with some plans. We typically do not get paid for encounters by non-credentialed providers employed at FQHC. It can take up to several months before a provider is credentialed. What are options to continue to see patients or to improve the credentialing process with some plans. Harmony is the plan that comes to mind.	In most instances, MCOs and MCCNs will continue to work with providers while in the credentialing process and will reimburse them as out of network providers until credentialing process is complete.
205	Network & Provider Enrollment	If we are in Central Illinois region and we have clients who are enrolled in Family Health Network in the Chicago region can we be a provider for Family health Network?	A provider can enroll with any health plan, even if that health plan is not located in the providers region. There are many situations where a health plan enrollee may seek services in other regions, such as college students who are away temporarily.
206	Network & Provider Enrollment	Since Illinicare is taking over the claims processing for CountyCare, do our providers have to contract with CountyCare directly or do we contract with Illinicare?	Providers will contract with CountyCare to participate as a provider in the CountyCare network.
207	Network & Provider Enrollment	We are a multi specialty physician's group do each of our providers who want to participate have to individually enroll in the MCO plans or would we enroll as a group. we have over 50 physicians and all will not be enrolling	Each MCO or MCCN may have different policies. Even if you enroll under a group name, the information and Medicaid provider number for each individual provider would have to be obtained for many purposes, such as determining network adequacy, claims payment and encounter data. The Department requires that each provider in an MCO or MCCN be enrolled in Medicaid with and Medicaid Provider number.

	Category	Question	Response
208	Network & Provider Enrollment	We would like to see the Pharmacy Benefits Managers (third-party administrators for pharmacy benefits) listed for the MCOs also, please.	The Department agrees that this would be helpful and will develop the list and post the care coordination website.
209	Network & Provider Enrollment	Currently neither of our two hospitals nor any of our employed PCPs participate in any of the managed care Health Plans. We are continuing to analyze and assess whether or not either of our two hospitals or individual PCPs will enroll in any of the new Health Plans, but in the meantime want to fully understand so we can educate and treat patients accordingly. When must a provider sign up to participate in managed care programs by?	While there are no set deadlines, the Department encourages providers to sign up with the health plans as soon as possible so that they will be able to continue seeing their patients with no disruption in care. Given the roll-out schedule, all providers should now be actively enrolling with the health plans.
210	Network & Provider Enrollment	We are Public Health District that provides service only to Township Residence. We have Medical, Podiatry, Dental, MENTAL HEALTH SERVICES. Most of the services we provide to the Community are free. They pay their property taxes and a very very small % the district gets to be able to provide the services. In MENTAL HEALTH we follow RULE 132. Once we are in NETWORK with all the plans do we have to take patients that are not in the TOWNSHIP. Also, once everyone is enrolled in a program is DHS and HFS going to update ALL the manual? Currently what's on your website is out of date.	As a network provider, you can work with the MCO or MCCN to discuss your panel size and whether to have a closed panel. The ICES cannot limit enrollment by county or zip code. Talk to the health plan about your preferences and the best way for you to participate. FOR ACE and CCE enrollees, providers not enrolled with an ACE or CCE as an IHC PCP, do not have to accept clients outside of the area they serve. It is recommended that you work with the ACE and CCE health plans to ensure they understand your area of service.
211	Outreach & Marketing	I just received the HFS newsletter regarding the new care coordination plan. We will be having our annual health fair on Wednesday, August 6th, and I think it's a perfect opportunity to invite these organizations to do outreach in our community. I noticed that the invitation must be extended to all of them with 30-day notice. Would you be able to provide us with the contact information for these programs?	The Health Plan contacts are listed in the provider notice dated June 24, 2014 and can be found at http://www.hfs.illinois.gov/assets/062414n.pdf.

	Category	Question	Response
212	Outreach & Marking	*Regarding the new marketing restriction about not using computers in the hospital to enroll:* Do we have place signs prohibiting families from enrolling online or actively block the enrollment website from our network to prevent families from using the computers in our patient rooms and other public areas from enrolling? Or, is it sufficient for us simply not to direct or encourage families to use hospital computers to enroll?	It is sufficient not to direct or encourage families to use hospital computers to enroll.
213	Outreach & Marking	*Regarding the new marketing restriction about not using computers in the hospital to enroll:* Are families prohibited from using their own computers, phones, tablet devices, etc. using our wireless network? If so, do we need to actively block the site or place signs in the hospital telling them it is prohibited?	Families are not prohibited from using their own computers, phones, tablet devices, etc. using the hospital's wireless network.
214	Population & Eligibility	I believe when this was first discussed, that anyone in a waiver program would not be included in this roll out. Is that still correct?	That is not correct. Eligible Enrollees included in the PD, HIV, TBI, Elderly or SLF waiver will be sent an enrollment packet. These are the same waiver programs included in the Department's Integrated Care Program and the MMAI demonstration.
215	Population & Eligibility	Currently, patients who are foster children, and patients who have Medicaid as a secondary insurance and a commercial policy plan as their primary insurance, are exempt from selecting a PCP. Will this change with care coordination?	No.
216	Population & Eligibility	Will this affect those under the Illinois Breast and Cervical Cancer Program?	No, since the Breast and Cervical Cancer Program is a limited benefit program, clients eligible for that program are not eligible to enroll in health plans.
217	Population & Eligibility	How will anyone know when a child has gone 3 months without coverage? I was told this morning that these uninsured children will need to re-enroll. Will we be notified?	A child is eligible for AllKids coverage in the highest income AllKids group, AllKids Premium Level 2, after 3 months (not 12 months as previously) without insurance. This applies only at initial application. No child who is currently covered is required to reapply because they have other insurance coverage. Medical providers and health plans can verify children's eligibility through MEDI.

	Category	Question	Response
218	Population & Eligibility	There is some confusion regarding applications for Medicaid (AABD) that were accepted previously, after being determined eligible to receive SSI. Is an adult who has been approved for SSI still eligible to receive adult Medicaid following the completion of the application or does the determination of a disability from social security not have any bearing as to the eligibility of Adult Medicaid ?	The determination of disability has no bearing on the eligibility for the new ACA Adult group. People who have applied for SSI, or those who have already been determined eligible for SSI, who apply for medical after 1/1/14 will be determined for ACA adult eligibility if they meet the financial, residency, citizenship criteria, AND are ages 19 through 64, are NOT enrolled in Medicare, are not parents or caretaker relatives raising minor children, are not pregnant women, and have not been determined eligible as former foster care. Those individuals with disabilities who had previously (prior to 1/1/14) been found eligible for Medicaid coverage in the AABD group will remain in the AABD category, as long as they meet the eligibility criteria.
219	Population & Eligibility	What about those with a spenddown? Will spenddown go away?	No. Clients with a spenddown are an excluded population and therefore are not eligible to enroll in a health plan. However, there is no more spenddown for ACA adults or for Family/Caregiver adults (FHP adults).
220	Population & Eligibility	What about those that got Medicaid when they signed up through the Affordable Care Act? Will they also be placed in a managed care network?	Yes, adults eligible through the Affordable Care Act will also participate in the health plans.
221	Population & Eligibility	Will children with or without disabilities who have court orders for Medicaid through foster care adoption, or other similar circumstances have to switch to a managed care...also what if during the lock in period there is a major life change that does not allow for change. Example a child in a plan, due to crisis goes into long term care and the medical director is not in that child's plan. This is currently a problem for us, we have tried during this lock in period to switch and was told no. Kids over 18 who are in our children's home, and adults in our group homes have had to switch PCP, or we get a new card every month with a different doctors name on it....which involves many calls to providers to correct the problem and they don't know why it is happening.	DCFS ward and DCFS foster children are exempt from enrollment in health plans. If a child is taken into DCFS custody and the DCFS indicator is added to the eligibility on the Department's system, the child would be disenrolled from the MCO. Otherwise the MCO would be responsible for ensuring access to services. Any complicated issues could be worked on an individual basis with Department staff.
		When a child is granted DCFS status and under a MCO will they be terminated as was before and where will the care go if so?	
		Will DCFS wards also be enrolled into any of the Managed Care Entities?	

	Category	Question	Response
		I just wanted to verify that DCFS wards in the care coordination counties would be included in the population that will be required to choose an MCE. Will DCFS wards be placed in MCO?	
222	Population & Eligibility	Are duals on the Adults with DD waiver also exempt? Director Hamos stated that this is not part of Phase III which will affect persons with developmental disabilities who are in long term waiver care (CILA, ICFDD, etc.) However, several of the individuals who are in our care as a CILA provider, have been told they are being enrolled in managed care. Can you please clarify this? You talk about nursing home individuals, does this include individuals with DD in ICF/ DD facilities or CILA group homes?	DD institutional residents and DD HCBS waiver clients are required to join the ICP and FHP Program for their medical services. Their DD services (Service Package 3) are carved out of these programs and remain paid for and operated by DHS. DD institutional residents and DD HCBS waiver clients are exempt from the MMAI program.
223	Population & Eligibility	Does this affect children who receive Medicaid under Title IV-E as part of their adoption subsidy?	No.
224	Population & Eligibility	If CountyCare patients receive re-determination letters regarding their plan, how do we address this situation?	Beginning 7/1/14 CountyCare is an MCCN like any other MCO or MCCN. They are no longer performing any eligibility functions as they did during the Cook County waiver. Any clients that receive redetermination letters should follow the instructions in the letter.
225	Population & Eligibility	Can dual eligibles be enrolled in a CCE?	No
226	Population & Eligibility	Please clarify whether or not clients who only have a developmental disability can enroll in a CCE. We have been told that for the CCEs the person must have a mental health diagnosis, however we have some clients who are only DD who received letters that included the option of enrollment in a CCE.	The CCEs serve clients that are eligible for Medicaid because they are a Senior or Person with a Disability (the eligibility category of AABD). While most of the CCEs are specializing in treating clients with a mental health diagnoses, any SPD can choose to enroll in a CCE.
227	Population & Eligibility	As a case manager with the ability to check MEDI is there something that describes which program a person is enrolled in. for example: MMAI or ICP?	Yes, MEDI will identify the name of the health plan in which the client is enrolled.
228	Population & Eligibility	How will the redetermination phase for Medicaid effect enrollment?	Enrollees are encouraged to meet their redetermination requirements to avoid cancellation and an interruption in care. Enrollees who lose eligibility at redetermination will be automatically disenrolled when their Medicaid coverage ends. If they regain eligibility within two months, they will be re-enrolled in their previous health plan when possible.

	Category	Question	Response
229	Population & Eligibility	Is CHIP being rolled up under Family Health Plan (previously known as TANF) or will it still be a separate program?	Yes, FHP includes the population formerly known as TANF. It includes children and their parents/caregivers.
230	Population & Eligibility	Is eligibility still determined on a month to month basis? Will we be able to query future dated eligibility or just the current month?	Eligibility is not determined on a month to month basis. However, eligibility status is provided retrospectively up to the current month. Eligibility can be queried for retrospective periods and current month.

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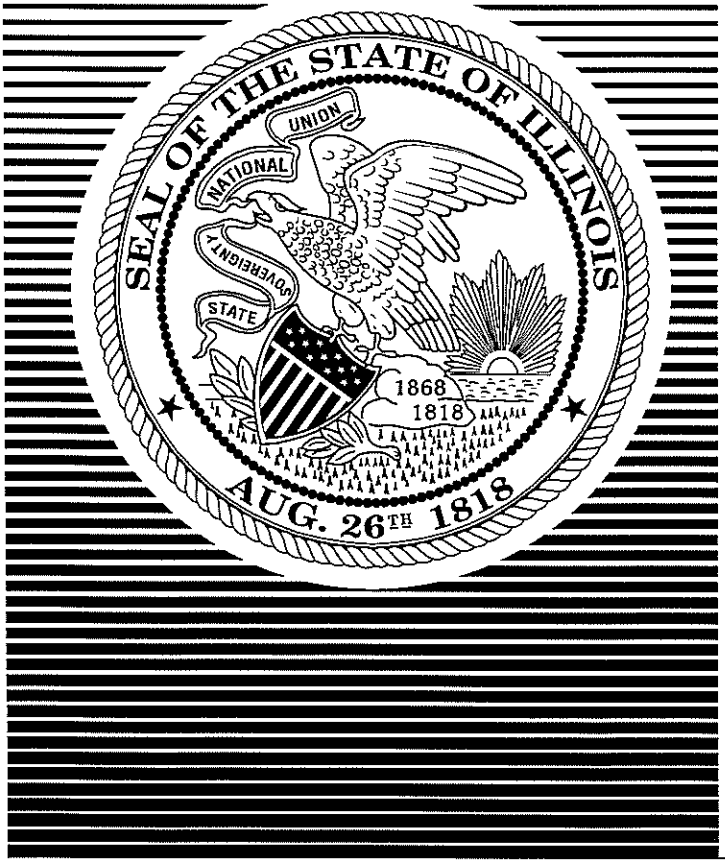

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Medical Payment

2) Code Citation: 89 Ill. Adm. Code 140

3)

Section Number:	Proposed Action:
140.418	Amendment

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]

5) Complete Description of the Subjects and Issues Involved: This rulemaking is submitted pursuant to PA 98-651, which mandates that upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan, the Department of Healthcare and Family Services (HFS) shall authorize the Chicago Public Schools (CPS) to procure a vendor or vendors to manufacture eyeglasses for individuals enrolled in a school within the CPS system.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rule currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? Yes

Section Numbers:	Proposed Action:	*Illinois Register* Citation:
140.12	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.440	Amendment	37 Ill. Reg. 19971; December 20, 2013
140.80	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.82	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.84	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.86	New Section	38 Ill. Reg. 14658; July 18, 2014
140.420	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.421	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.425	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.442	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.457	Amendment	38 Ill. Reg. 14658; July 18, 2014

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

140.458	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.472	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.485	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.488	Amendment	38 Ill. Reg. 14658; July 18, 2014
140.Table D	Repeal	38 Ill. Reg. 14658; July 18, 2014
140.20	Amendment	38 Ill. Reg. 16096; August 1, 2014
140.25	Amendment	38 Ill. Reg. 16096; August 1, 2014
140.413	Amendment	38 Ill. Reg. 16468; August 8, 2014
140.462	Amendment	38 Ill. Reg. 16468; August 8, 2014

11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue E., 3rd Floor
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217/782-1233
HFS.Rules@illinois.gov

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this Rulemaking was Summarized: July 2014

The full text of the Proposed Amendments begin on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

2013; amended at 37 Ill. Reg. 18275, effective November 4, 2013; amended at 37 Ill. Reg. 20339, effective December 9, 2013; amended at 38 Ill. Reg. 859, effective December 23, 2013; emergency amendment at 38 Ill. Reg. 1174, effective January 1, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. 4330, effective January 29, 2014; amended at 38 Ill. Reg. 7156, effective March 13, 2014; amended at 38 Ill. Reg. 12141, effective May 30, 2014; amended at 38 Ill. Reg. 15081, effective July 2, 2014; emergency amendment at 38 Ill. Reg. 15673, effective July 7, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. _____, effective _____.

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

Section 140.418 Department of Corrections Laboratory

All lenses, frames and frame parts shall be obtained from the Department of Corrections (DOC) laboratory and, upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan, a vendor or vendors procured by the Chicago Public Schools (CPS) to manufacture eyeglasses for individuals enrolled in a school within the CPS system. DOC shall not engage in "office" services, such as examinations or dispensing of eyeglasses to recipients~~, but shall be the State's laboratory for fabrication of eyeglasses~~. Individual optical suppliers shall continue to provide examinations, frame repairs, contact lenses, artificial eyes and low vision devices, as well as dispensing of eyeglasses obtained from the DOC laboratory or CPS vendor. CPS shall ensure that its vendor or vendors are enrolled as providers in the Medical Assistance Program and, as applicable, in a managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Claims for services provided by DOC or CPS' vendor or vendors shall be submitted to the Department of Healthcare and Family Services (Department) or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses~~Payment for fabrication of eyeglasses shall be made by the Department of Public Aid directly to the Department of Corrections~~.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PUBLIC INFORMATION

1. Statute requiring agency to publish information concerning proposed changes in methods and standards for establishing medical assistance payment rates for medical services in the Illinois Register: 5 ILCS 100/5-70(c)

2. Summary of Information: The Department of Healthcare and Family Services (HFS) proposes to change the methods and standards by which certain services are reimbursed under the Illinois Medical Assistance Program, pursuant to SB 0741.

Prior Approval for Antipsychotic Medications and Complex Kids: Provides that the Department exempt antipsychotic medications from the four prescription policy and allows the Department to exempt children with complex medical needs enrolled in a care coordination entity that are contracted with the Department to solely coordinate care for such children, if the Department determines that the entity has a comprehensive drug reconciliation program. Antipsychotic medications will no longer be rejected when the client has exceeded four prescriptions in the preceding thirty-day period. Children with complex medical needs enrolled in such care coordination entities will not receive four prescription policy rejections for their medications, and will not be subject to the four prescription policy.

Annual cost is estimated at $5 million and is effective for dates of service on or after July 1, 2014.

Adult Dental: Provides that the Department discontinue the limitation of adult dental services to emergency services only.

Annual cost is estimated at $35 million and is effective July 1, 2014.

Transitional Care Children: Provides for an increased rate or payment for services provided for the purpose of transitioning children from a hospital to home placement or other appropriate setting by a children's community-based health care center authorized under the Alternative Health Care Delivery Act. The rates for transitional care services will be $683 per day.

Annual cost is estimated at $500,000 and is effective July 1, 2014.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PUBLIC INFORMATION

Home Health Visit and Nursing Assistant Rates: Provides for an increase to the rate or payment for an all-inclusive visit provided by a home health agency and for hourly shift nursing services rendered by a certified nursing assistant (CNA). The rates paid to home health agencies will be increased to $72 for all-inclusive visits and $20 per hour for shift nursing services rendered by CNAs.

Annual cost is estimated at $6 million and is effective on July 1, 2014.

3. Name and address of person to contact concerning this information:

Bureau of Program and Reimbursement Analysis
Division of Medical Programs
Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0001
E-mail address: HFS.bpra@illinois.gov

Interested persons may review these proposed changes on the HFS Public Involvement Web page <http://www2.illinois.gov/hfs/PublicInvolvement/>. Local access to the Internet is available through any local public library. In addition, this material may be viewed at the DHS local offices (except in Cook County). In Cook County, the changes may be reviewed at the Office of the Director, Illinois Department of Healthcare and Family Services, 401 South Clinton Street, Chicago, Illinois. The changes may be reviewed at all offices Monday through Friday from 8:30 a.m. until 5:00 p.m. This notice is being provided in accordance with federal requirements found at 42 *CFR* 447.205.

2014

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Rules of
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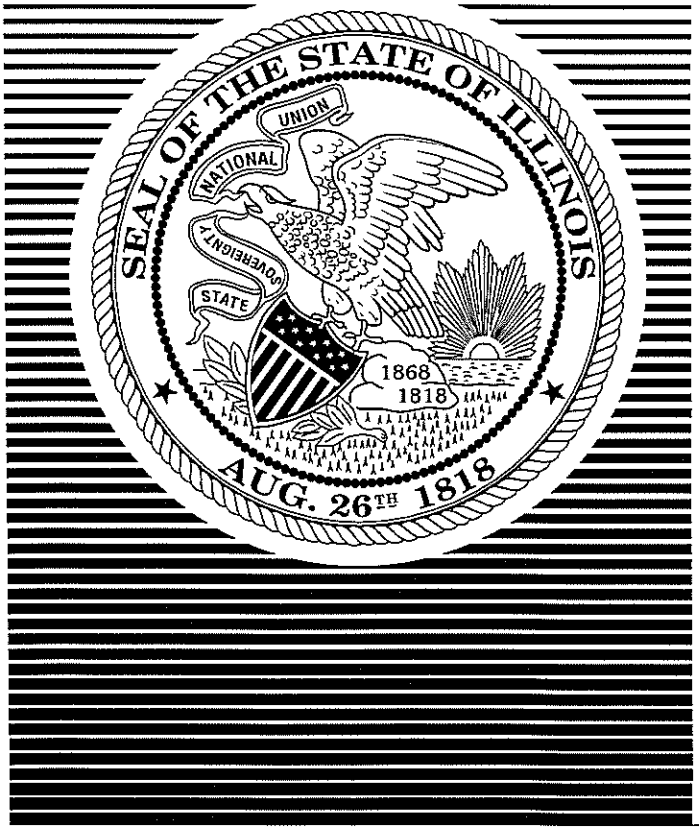

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~B) treatment necessary to correct a condition that constitutes a handicapping malocclusion (A malocclusion is handicapping if there is an impairment of or a hazard to the ability to eat, chew, speak or breathe that is related to the malocclusion.);~~

~~15) Analgesia (nitrous oxide);~~

~~16) Therapeutic drug injection;~~

~~17) Other drugs and medicaments;~~

~~18) Unspecified miscellaneous adjunctive general services procedure or service;~~

~~19) Dental services not included in the Department's Schedule of Dental Procedures (see Table D of this Part).~~

b) The dentist may request post-approval when a dental procedure requiring prior approval is provided on an emergency basis. Approval of the procedures shall be given if the dental procedure is medically necessary. ~~in the judgment of a consulting dentist of the Department or a consulting dental service, the procedure is necessary to prevent dental disease or to restore and maintain adequate dental function to assure good bodily health and the well-being of the patient.~~

~~c) Payment for complete and partial dentures is limited to one set every five years if necessary to replace lost, broken or unusable dentures; payment for a bridge is limited to once in five years. Bridgework will be reimbursed only if there has not been placement of a partial denture within the prior five years.~~

~~d) Root canals, apexification, and apicoectomy procedures are covered for children for anterior teeth, bicuspids, and permanent first molars. Root canals are covered for adults only for anterior teeth.~~

~~e) Panoramic x-rays are covered only once every three years.~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.425 Podiatry Services

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

a) Payment for podiatry services shall be made only to licensed podiatrists.

b) Effective July 1, 2012 through September 30, 2014, payment shall be made for those podiatric services provided to recipients under the age of 21 or recipients age 21 and over who have been diagnosed with diabetes as defined in the International Classification of Diseases. The allowable diagnosis code ranges will be reflected~~specified~~ in the Handbook for Providers of Podiatric Services.

c) Payment shall be made for the following:

1) Effective July 1, 2012 through September 30, 2014, payment shall be made for those podiatric services that are:

A~~1~~) Limited to recipients under the age of 21 or recipients age 21 and over who have been diagnosed with diabetes as defined in the International Classification of Diseases.

B~~2~~) Essential for the diagnosis and treatment of conditions of the feet.

C~~3~~) Listed in the Current Procedural Terminology (CPT) fourth edition published by the American Medical Association, for podiatric office visits, diagnostic radiology, pathology, or orthomechanical procedures included in the Department's schedule of podiatric services.

D~~4~~) Performed by the podiatrist or under the direct supervision of the podiatrist.

E~~5~~) Routine foot care services (trimming of nails, treatment of calluses, corns, and similar services) when a participant is under active treatment for diabetes mellitus.

2) Effective October 1, 2014, payment shall be made for those podiatric services that are:

A) Essential for the diagnosis and treatment of conditions of the feet.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

B) Listed in the CPT for podiatric office visits, diagnostic radiology, pathology, or orthomechanical procedures included in the Department's schedule of podiatric services.

C) Performed by the podiatrist or under the direct supervision of the podiatrist.

D) Routine foot care services (trimming of nails, treatment of calluses, corns, and similar services) when a participant is under active treatment for diabetes mellitus.

d) Payment shall not be made for the following services:

1) Making a referral, obtaining a specimen, handling a specimen for analysis, or ordering a laboratory test;

2) Visits and services provided to recipients eligible for Medicare benefits if the services are determined not medically necessary by Medicare;

3) Services provided to recipients in group care facilities by a podiatrist who derives direct or indirect profit from total or partial ownership of the facility;

4) Routine foot care, except as described in subsection (c)(1)(E)~~(5)~~;

5) Screening for foot problems;

6) Provider transportation costs;

7) X-rays, and laboratory procedures performed at a location other than the podiatrist's own office;

8) X-rays, laboratory work or similar services not specifically required by the condition for which the recipient is being treated;

9) Routine post-operative visits.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

C) Anti-Rejection Drugs.

2) Brand name prescription drugs are exempt from the prior approval requirements of this subsection (d) if:

A) there are no generic therapies for the condition treated within the same therapeutic drug class; or

B) the Department determines that the brand name prescription drug is cost effective.

e) Effective July 1, 2012, the Department may require prior approval prior to reimbursement for a prescription drug if the patient for whom the drug is prescribed has already received four prescription drugs in the preceding 30-day period. For purposes of this subsection (e)~~(d)~~, prescription drugs in the following therapeutic classes shall not count towards the limit of four prescription drugs and shall not be subject to prior approval requirements because a patient has received four prescription drugs in the preceding 30 days:

1) Antiretrovirals;

2) Antineoplastics;~~ and~~

3) Anti-Rejection Drugs; and~~.~~

4) Effective July 1, 2014, Antipsychotics.

f) Effective July 1, 2014, the Department shall exempt from the prior approval process required under subsection (e) children with complex medical needs enrolled in a care coordination entity contracted with the Department to solely coordinate care for those children, if the Department determines that the entity has a comprehensive drug reconciliation program.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.457 Therapy Services

Effective July 1, 2012, physical, occupational and speech/language services are provided for

clients because of illness, disability or infirmity and in accordance with a plan established by a physician and reviewed by the physician every 90 days and, through September 30, 2014, with a maximum of 20 visits allowed per discipline per State fiscal year for adults age 21 and over. Payment may be made for prior approved therapy services provided by:

a) A physical, speech or occupational therapist who is qualified as follows:

1) A physical therapist must be licensed by the Department of Financial and Professional Regulation.

2 A speech/language therapist must be licensed by the Illinois Department of Financial and Professional Regulation.

3) An occupational therapist must be licensed by the Department of Financial and Professional Regulation.

b) A community health agency.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.458 Prior Approval for Therapy Services

a) Effective July 1, 2012 through September 30, 2014, prior approval is required for the provision of services by an independent speech/language, physical or occupational therapist or by a community health agency, unless:

1) the individual is eligible for services under Medicare; or

2) the individual is under the age of 21.

b) Effective October 1, 2014, prior approval shall be required for all individuals, except for individuals eligible for services under Medicare and except when the individual is under age 21 and the date of service is prior to July 1, 2015.

c~~b~~) Approval will be granted when, in the judgment of a consulting physician and/or professional staff of the Department, the services are medically necessary and appropriate to meet the individual's medical needs.

d~~c~~) The decision to approve or deny a request for prior approval will be made within

21 days after the date the request and all necessary information is received.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.472 Types of Home Health Care Services

The types of services for which payment can be made are:

a) Intermittent skilled nursing in the home for the purpose of completing an assessment, evaluation or administration.

b) Shift nursing care in the home for the purpose of caring for a participant under 21 years of age who has extensive medical needs and requires ongoing skilled nursing care.

c) Home health aide.

d) Therapy services: Effective July 1, 2012 through September 30, 2014, speech, occupational and physical therapy services are limited to a maximum of 20 visits per State fiscal year for participants who are age 21 and over. For services provided on and after October 1, 2014, these~~These~~ services require prior approval by the Department for participants age 21 and over. For services on or after July 1, 2015, these services shall require prior approval by the Department for participants under age 21.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 140.485 Healthy Kids Program

a) Program Description

1) The Healthy Kids Program is the Early and Periodic Screening, Diagnosis and Treatment Program mandated by the Social Security Act (see 42 USC~~U.S.C.~~ 1396a(43), 1396d(4)(B) (Supp. 1987)). The goals of the program are to:

A) improve the health status of Medicaid-eligible children ages birth through 20 years through the provision of preventive medical care and early diagnosis and treatment of conditions threatening the

2014

ILLINOIS

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Rules of
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Index Department
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Illinois Department of Healthcare and Family Services
March 11, 2015

Summary of Public Notice for IL SPA 14-0041 – Alternative Benefit Plan Realignment

The ACA Adult group and the EPSDT population affected by the service delivery system changes in IL SPA 14-0041 were notified of those changes according to the mailing schedule available at http://www2.illinois.gov/hfs/SiteCollectionDocuments/CC__mailsched.pdf. Clients received an enrollment packet containing:

- An initial enrollment letter; customized with the various health plan/care coordination options in their service area;
- A tip sheet, including resources available to clients looking for help in picking a health plan; and
- A brochure about how to enroll in a health plan.

Unresponsive clients received a second enrollment letter to advise that they would be automatically enrolled if they did not pick a plan. These materials (including sample letters) are attached.

As you know, notices of the changes in covered services were published in the Illinois Register; supporting documentation has been uploaded in the MMDL with ABP5. Additionally, clients in health plans are notified of changes to covered services by their health plan within 30 days.

The service changes originated in SB741, which restored certain services that were cut in the 201 SMART Act. In addition to the notices published in the Illinois Register (part of the MMDL submission), the changes were addressed in the Medicaid Advisory Committee's session on July 2014 (http://www2.illinois.gov/hfs/SiteCollectionDocuments/071114_mac.pdf and http://www2.illinois.gov/hfs/SiteCollectionDocuments/071114_macminutes.pdf) and posted to our website at http://www2.illinois.gov/hfs/SiteCollectionDocuments/FY2015SB741.pdf .