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State/Territory Name: Illinois

State Plan Amendment (SPA) #: 20-0004

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



April 24, 2020

Theresa Eagleson
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0001

Re: Illinois State Plan Amendment (SPA) 20-0004

Dear Director Eagleson:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 20-0004. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

The State of Illinois requested a modification of the requirement to submit SPAs related to the COVID-19 emergency by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 C.F.R. §430.20. CMS is approving this request pursuant to section 1135(b)(5) of the Act.

The State of Illinois also requested a waiver of public notice requirements applicable to the state plan amendment (SPA) submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to ABPs. These requirements help to ensure that the affected public has reasonable opportunity to comment on these SPAs. CMS recognizes that during this public health emergency, Illinois must act expeditiously to protect and serve the general public. Therefore, under sections 1135(b)(1)(C) and 1135(b)(5) of the Act, CMS is approving the state's request to waive these notice requirements applicable to this SPA.

The State of Illinois also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Under section 1135(b)(5) of the Act, CMS is also approving the State of Illinois's request for flexibility to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These approvals under section 1135 only apply with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to ABPs to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof). Even though CMS is approving this waiver, we encourage the state to make all relevant information available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Illinois's Medicaid SPA Transmittal Number 20-0004 is approved effective March 1, 2020. Please note that the effective date for the new COVID-19 testing eligibility group described at section 1902(a)(10)(A)(ii)(XXIII) of the Act is March 18, 2020. For payment provisions included in SPA the following effective dates are approved: March 9, 2020 for Section E.1 and March 17, 2020 for Section E.2.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Courtenay Savage at 312-353-3721 or by email at Courtenay.Savage@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Illinois and the health care community.

Sincerely,

Anne M.
Costello -S

Digitally signed by Anne
M. Costello -S
Date: 2020.04.24
14:41:03 -04'00'

Anne Marie Costello
Deputy Director
Center for Medicaid & CHIP Services

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER 20-0004	2. STATE: ILLINOIS
	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: March 1, 2020	

5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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


6. FEDERAL STATUTE/REGULATION CITATION: Title XIX and Section 1135 of the Social Security Act ces 4/22/20	7. FEDERAL BUDGET IMPACT a. FFY 2020 \$75.2 Million (Quarterly) b. FFY 2021
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: N/A	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): N/A

10. SUBJECT OF AMENDMENT:

Medicaid State Plan Disaster Relief State Plan Amendment

11. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- OTHER, AS SPECIFIED: Not submitted for review by prior approval.

 13. TYPED NAME: Theresa Eagleson 14. TITLE: Director of Healthcare and Family Services 15. DATE SUBMITTED 4/6/2020	16. RETURN TO: Department of Healthcare and Family Services Bureau of Program and Reimbursement Analysis Attn: Mary Doran 201 South Grand Avenue East Springfield, IL 62763-0001
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FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 6, 2020	18. DATE APPROVED: April 24, 2020
PLAN APPROVED—ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: March 1, 2020	20. SIGNATURE OF REGIONAL OFFICIAL: Anne M. Costello -S <small>Digitally signed by Anne M. Costello -S Date: 2020.04.24 14:41:34 -0400</small>
21. TYPED NAME Anne Marie Costello	22. TITLE: Deputy Director, CMCS
23. REMARKS:	

State/Territory: Illinois

Section 7 – General Provisions

7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in the Illinois Medicaid state plan, as described below:

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The state will provide notice within 24 hours of submission.

Section A – Eligibility

1. The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

COVID 19 Testing for the Uninsured: *The state intends to cover the 1902 (a) (10) (A) (ii) (XXIII) and 1902 (ss) group effective March 18, 2020 which includes those affected by COVID 19. There is no maximum income or resource limit. The individual must be uninsured.*

2. The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

Eliminate Resource Test: The state requests elimination of the resource test in determining eligibility for ABD, HBWD (Ticket to Work), and Medicare Savings Program individuals. This includes the following groups:

- Mandatory ABD group for 209(b) States--1902(f)
- Qualified Medicare Beneficiaries--1902(a)(10)(E)(i)
- Specified Low-Income Medicare Beneficiaries--1902(a)(10)(E)(iii)
- Qualifying Individuals--1902(a)(10)(E)(iv)

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- Age and Disability-Related Poverty Level Group--1902(a)(10)(A)(ii)(X)
- Ticket to Work Basic/TWWIIA Basic--1902(a)(10)(A)(ii)(XV)
- Medically Needy Individuals under 21--1902(a)(10)(C)
- Medically Needy Individuals Based on Age, Blindness, or Disability--1902(a)(10)(C)

4. The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
5. The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

2. X The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Presumptive Eligibility for MAGI Adults: The state chooses to add Presumptive Eligibility for MAGI parents and caretaker relative adults eligible under 1902 (a) (10) (A) (i) I, former foster care under 1902 (a) (10) (A)(i) (IX), pregnant women as identified in the eligibility groups listed in SPA 14.0003 (S28), and Medicaid Expansion Adults eligible under 1902(a)(10)(A)(i)(VIII).

More Frequent PE for Children and Adults: The state requests to change the children’s limit on PE periods to two times per calendar year and to apply this new limit to PE under the newly requested MAGI categories.

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3. The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

The state requests to change the limit for presumptive eligibility for pregnant women to two times in a calendar year.

4. The agency adopts a total of months (not to exceed 12 months) continuous eligibility for children under age enter age (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. The agency uses a simplified paper application.
 - b. The agency uses a simplified online application.
 - c. The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

2. The agency suspends enrollment fees, premiums and similar charges for:
- a. All beneficiaries
 - b. The following eligibility groups or categorical populations:

Premiums are suspended for those enrolled in the Ticket to Work (Medicaid Buy-In) program, the only Title XIX program that currently requires premiums.

3. The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

State/Territory: Illinois

Section D – Benefits

Benefits:

1. The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. The agency makes the following adjustments to benefits currently covered in the state plan:

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

- b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Telehealth:

5. X The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

The state has added virtual check-in visit and e-visit codes to the [COVID-19 Virtual Healthcare Expansion Fee Schedule](#). Additionally, FQHCs, RHCs, Encounter Rate Clinics and Critical Clinic Providers may bill these codes, fee-for-service, at the rate established by the Department as

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listed on the [COVID-19 Virtual Healthcare Expansion Fee Schedule](#). The clinics identified above will not receive their established encounter rate for virtual check-in visits and e-visits.

Drug Benefit:

6. The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

7. Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

9. The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. Newly added benefits described in Section D are paid using the following methodology:

- a. Published fee schedules –

Effective date (enter date of change): March 9, 2020

Location (list published location): <https://www.illinois.gov/hfs/Pages/coronavirus.aspx>

- b. Other:

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

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Effective March 17, 2020, facility per diem rates will be increased by 20% for ICF/DD and MC/DD facilities.

- a. Payment increases are targeted based on the following criteria:

Facilities licensed by the Department of Public Health under the ID/DD Community Care Act as an ID/DD [210 ILCS 47] facility and medically complex for the developmentally disabled facilities licensed under the MC/DD Act [210 ILCS 46].

- b. Payments are increased through:

- i. A supplemental payment or add-on within applicable upper payment limits:

[Empty box for supplemental payment details]

- ii. An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: 20%

Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

Up to the Medicare payments for equivalent services.

By the following factors:

[Empty box for factors]

Payment for services delivered via telehealth:

3. For the duration of the emergency, the state authorizes payments for telehealth services that:

- a. Are not otherwise paid under the Medicaid state plan;
b. Differ from payments for the same services when provided face to face;
c. Differ from current state plan provisions governing reimbursement for telehealth;

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The state has added virtual check-in visit and e-visit codes to the [COVID-19 Virtual Healthcare Expansion Fee Schedule](#). Additionally, FQHCs, RHCs, Encounter Rate Clinics and Critical Clinic Providers may bill these codes, fee-for-service, at the rate established by the Department as listed on the [COVID-19 Virtual Healthcare Expansion Fee Schedule](#). The clinics identified above will not receive their established encounter rate for virtual check-in visits and e-visits.

- d. Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
 - i. Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
 - ii. Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

- 4. Other payment changes:

Section F – Post-Eligibility Treatment of Income

- 1. The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. The individual’s total income
 - b. 300 percent of the SSI federal benefit rate
 - c. Other reasonable amount: _____
- 2. The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

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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 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. 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. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

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Supersedes TN: New

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Effective Date: 03/01/2020